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Verify & Comply

8th Edition

Credentialing, Medical Staff, and Ambulatory Care Standards

Stephanie Russell, BS, CPMSM, CPCS | Janet Wilson, CPMSM, CPCS, FMSP

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About the Authors

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Stephanie Russell, BS, CPMSM, CPCS, is the regional director of medical staff services and credentialing at UCHealth in Colorado Springs, Colorado. She has been an executive medical staff services professional for over 30 years, overseeing medical education, graduate medical education, bylaws, regulatory compliance and accreditation, health system credentialing for both hospitals and health plans, credentialing service contracts for outside entities, as well as delegation agreements and audits.

She recently moved from the Midwest after a lifelong career in northern Illinois to Colorado Springs, joining the UCHealth team at Memorial Central Hospital. She now oversees four facilities, with three medical staffs, including a critical access hospital. She is a NAMSS instructor and has made many presentations at state and national educational conferences on topics related to credentialing, privileging, professional development, and regulatory compliance for both NCQA and The Joint Commission. She has also been a collaborator and coach with Team Med Global since its inception, expanding her teachings to include practice management, managed care, and quality for medical staffs and hospitals.

As a past member of the NAMSS Board of Directors and Illinois Association Medical Staff Services Board of Directors, she has displayed her leadership skills and innovative perspectives and is known for "asking the tough questions." She was instrumental in creating the NAMSS course on Leadership, teaching the course the first two years it was offered by NAMSS. She coauthored the seventh edition of *Verify and Comply: Credentialing, Medical Staff, and Ambulatory Care Standards*. In addition to credentialing, she loves helping individuals be the best they can be and is passionate about this industry. She frequently tells her audiences if you don't love what you do, find something else to do; life is too short to work in a profession that you don't enjoy. Her email tag line is "enjoy the day — it's a gift," and she lives each day as if she's received a present.

Janet Wilson, CPMSM, CPCS, FMSP

Janet Wilson, CPMSM, CPCS, FMSP, has been involved in the medical staff services, quality, and credentialing industry for the past 34 years. Her healthcare experience extends to hospitals, quality, managed care, and the CVO environment. She has been a NAMSS instructor for 11 years and has coauthored and contributed to NAMSS curriculum including Cred 100, Cred 101, Cred 201, Ready to Lead?, and Managed Care Basics. She holds a Bachelor of Science in Health Administration and is CPMSM and CPCS certified by NAMSS. She served for three years on the board

of directors of NAMSS. She also served on the board of directors of the Texas Society of Medical Staff Services and served as president during her tenure on the board. She has also been an independent educator and consultant for over 14 years in the areas of credentialing, CVO, quality, and medical staff services, with a primary focus on bylaws revisions, privilege form development, medical staff leadership education programs, and development and standardization of policies and procedures/documents across multiple hospital settings. She has taught on-site and virtual CPMSM/CPCS certification study groups and professional development courses for over 14 years. In 2012, she developed and launched a Certification Focused Study Program and teaches the Certification Program exclusively for EDGE-U-CATE, LLC, and is a member of their faculty. She also assists in teaching EDGE-U-CATE's Credentialing School.

Introduction

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

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

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

The Importance of Credentialing

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

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

Brief Descriptions of Each Organization

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

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

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

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

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

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

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

What This Book Includes

This book is divided into three sections:

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

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

Keeping Up to Date and Informed

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

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

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

SECTION 1

Acute Care and Managed Care: Credentialing Standards

Author's Note

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

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

CHAPTER 1

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

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

PRACTITIONERS COVERED				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
Nonphysicians: The CMS Surgical Services standards also address the privileging of nonphysicians "performing surgical tasks." The standards delineate practitioners such as dentists, oral surgeons, podiatrists, RN first assistants, nurse practitioners, surgical PAs, surgical technicians, etc. "Surgical tasks" are specifically defined within the standards. See the Interpretive Guidelines, §482.51. A certified registered nurse anesthetist must be supervised by an anesthesiologist who is immediately available, unless they are exempt from this according to CMS guidelines §482.69, which allow an opt-out if consistent with specific state law. *Note: If a hospital uses RNFAs, surgical PAs, or any non-MD/DO surgical assistants, the hospital must have criteria, qualifications, and a credentialing process to grant specific privileges to a practitioner based upon compliance with those criteria, and according to state and federal laws and regulations. This statement also applies to surgical tasks performed by practitioners under MD/DO supervision.* Tasks such as holding retractors, cutting or tying knots, and handling instruments are not considered performing surgery. However, cutting, burning, vaporizing, freezing, suturing, or manipulating tissue is considered surgery and thus requires privileging.	**Direction/supervision of the APRN may be through a collaborative or supervisory agreement. A vast majority of PAs, according to their licenses and appropriate state law, are required to have a supervisory agreement with a physician.* If organizations choose to credential and privilege APRNs or PAs under the equivalent process, the "Human Resources" chapter of the *Comprehensive Accreditation Manual for Hospitals (CAMH)* should be consulted for the methodology.** These standards require that the governing body approve an equivalent process (to the medical staff process) for the credentialing and privileging/reprivileging of PAs and APRNs. ***The equivalent process is not an option for hospitals that use Joint Commission accreditation for deemed status.* At a minimum, the equivalent process does the following: • Evaluates the credentials of the applicant*** • Evaluates the current competence of the applicant*** • Includes documented peer recommendations	DNV GL standards do not specifically address credentialing processes related to RN first assistants, surgical assistants, or physician employees who round with the physician. However, DNV GL provided an interpretation that these individuals' credentialing process and provision of care in the hospital must be governed by hospital policy. Further, DNV GL policy does not permit a physician employee who rounds with the physician to act as a scribe to the physician and make entries on the hospital medical record for physician signature.	• Physician assistant • Nurse practitioner • Clinical nurse specialist • Certified registered nurse anesthetist • Certified nurse midwife • Clinical social worker • Clinical psychologist • Registered dietitian or nutrition professional • Anesthesiologist assistant The governing body may grant physicians and nonphysicians medical staff privileges to practice at the hospital without being appointed to the medical staff. Nonphysician providers may be granted privilege delineation rights and responsibilities without being given membership status or rights. Other types of licensed healthcare professionals (e.g., physical therapists, occupational therapists, speech language therapists, licensed pharmacists) are generally not eligible for medical staff privileges unless the scope of practice permitted in their state makes them more comparable to these (above) types of nonphysician practitioners who in some states are permitted to provide patient care services, including monitoring and assessing of patients and ordering medications and laboratory tests.	• Nonphysician practitioners with an independent relationship with the organization who provide care under medical benefits. Examples of this category of practitioner would be a nurse practitioner, nurse midwife, optometrist, physical or occupational therapist, and speech and language therapist. Behavioral health practitioners are not included in file reviews, unless the organization does have these practitioners, in which case all types of the practitioner in the organization are reviewed. It is necessary to credential the following: • Practitioners with an independent relationship with the organization. An independent relationship is defined as when the organization selects and directs its members to a specific individual or group. This would include those practitioners that members can select as primary care practitioners. • Practitioners who are licensed, certified, or registered by the state and practice independently and are not required to be supervised.

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

CHAPTER 2

Acute Care and Managed Care: Reappointment, Renewal/Reappraisal of Clinical Privileges, and Recredentialing

MEDICAL EDUCATION				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
This element is considered static and therefore does not need to be reverified at the time of reappointment or renewal or revision of privileges.	This element is considered static and therefore does not need to be reverified at the time of reappointment or renewal or revision of privileges.	This element is considered static and therefore does not need to be reverified at the time of reappointment or renewal or revision of privileges.	This element is considered static and therefore does not need to be reverified at the time of reappointment or renewal or revision of privileges.	This element is considered static and therefore does not need to be reverified at the time of reappointment or renewal or revision of privileges.

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

CHAPTER 3

Acute Care and Managed Care: Other Credentialing Aspects

NOTIFICATION TO AUTHORITIES				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
Whenever a practitioner's privileges are limited, revoked, or in any way constrained, the hospital must, in accordance with state and/or federal laws and regulations, report those constraints to the appropriate state and federal authorities, registries, and/or databases, such as the NPDB. * **Reporting processes as required by state/ federal entity**	The Joint Commission does not have a specific standard requiring reporting of credentialing/privileging actions. However, The Joint Commission does require organizations to comply with applicable state and federal licensure requirements, laws, rules, and regulations. Thus, organizations must comply with federal (NPDB) and state reporting requirements. * **Reporting processes as required by state/federal entity**	DNV GL does not specifically require reporting of credentialing and/ or privileging actions. However, DNV GL does require organizations to comply with state and federal requirements. Thus, organizations must comply with federal (e.g., NPDB) and state licensure reporting requirements. * **Reporting processes as required by state/ federal entity**	Whenever a practitioner's privileges are limited, revoked, or constrained in any way, the hospital must report such actions to appropriate authorities (i.e., state and federal authorities, registries, and databases such as the NPDB). * **Reporting processes as required by state/ federal entity**	HP/MBHO: When an organization takes action against a practitioner for quality reasons, the action is reported to appropriate authorities. The organization offers the individual an appeal process. See Chapter 2, "Hearing/ Appeal Process," for requirements related to the appeal process. Objective evidence and patient care considerations are used by the organization when deciding whether a practitioner meets quality standards. Policies and procedures define the courses of action available to the organization as well as the appeal process available to the practitioner. The organization has clear policies and procedures describing when/how reporting occurs, to whom incidents are reported, and which incidents will be reported. When an organization suspends or terminates a practitioner's contract, there must be procedures for notifying appropriate authorities (e.g., state agencies). This reporting requirement applies to physicians as well as nonphysicians. If an organization participates in the NPDB, it must have a process to meet reporting requirements. CVO: Not applicable * **Policies/procedures outline the when, how, what, and to whom for reporting the suspension or termination of a practitioner contract**

EMERGENCY PRIVILEGES				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
Terminology not used. * **Statement in medical staff bylaws, policies/ procedures, or rules/ regulations along with a similar statement on the clinical privilege forms**	The Joint Commission standards no longer require "emergency" privileges to be addressed in medical staff documents. However, the "Rationale" section for temporary privileges does suggest addressing emergency privileges in medical staff bylaws or other documents for defined situations. It would be a best practice for medical staff documents to state that, in an emergency, any practitioner with clinical privileges is permitted to provide any type of patient care, treatment, and services that is intended to be lifesaving in nature or prevent serious harm (regardless of medical staff status or clinical privilege) as long as the patient care provided is within the scope of the individual's license. * **Statement in medical staff bylaws, policies/ procedures, or rules/ regulations along with a similar statement on the clinical privilege forms**	The medical staff bylaws shall include a process for approving practitioners for care of patients in the event of an emergency or disaster. * **Process for granting emergency/disaster privileges outlined in medical staff bylaws, policies/ procedures, or rules and regulations and applicable forms (i.e., emergency privileges statement included on clinical privileges forms)**	The medical staff bylaws provide for the medical staff chief/CEO to grant emergency privileges to a practitioner for purposes of lifesaving procedures during times that an appropriately credentialed practitioner is not available, within the scope of the practitioner's license. Generally, emergency privileges are limited to an "overwhelming disaster." Emergency privileges are not to be used for a practitioner who has not followed established medical staff regulations for application/ reapplication. * **Statement in medical staff bylaws** * **Form, with appropriate signatures, that documents the granting of emergency privileges**	Terminology not used.
COMMENTS/TIPS: See The Joint Commission column for a best practice for granting emergency privileges.				

SECTION 2

Medical Staff Acute Care Hospital Standards Not Related to Credentialing

CHAPTER 4

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

MEDICAL STAFF ACCOUNTABILITY			
CMS	**The Joint Commission**	**HFAP**	**DNV GL**
§482.12(a)(5) [The governing body must:] Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients. **Interpretive Guidelines §482.12(a)(5)** All hospital patients must be under the care of a practitioner who meets the criteria of 42 *CFR* 482.12(c)(1) and who has been granted medical staff privileges, or under the care of a practitioner who is directly under the supervision of a member of the medical staff. All patient care is provided by or in accordance with the orders of a practitioner who has been granted privileges in accordance with the criteria established by the governing body, and who is working within the scope of those granted privileges. **Interpretive Guidelines §482.22(b)(1)–(3)** The medical staff has oversight of all practitioners practicing in the hospital through processes such as peer review and making recommendations concerning privileging and reprivileging. The medical staff must be accountable to the hospital's governing body for the quality of medical care provided to the patients. The medical staff demonstrates its accountability through its exercise of its duties related to appointment of members of the medical staff, its conduct of reappraisals (including peer reviews), its approval of policies and procedures as required under other *Conditions of Participation* and its leadership participation in the organization and implementation of the hospital's quality assessment and performance improvement program required in accordance with §482.21.	**LD.01.03.01** **Accountability** The governing body is accountable for the safety, quality of care, treatment, and services provided to patients. **LD.01.05.01** **Medical Staff Structure** The hospital must have a self-governing organized medical staff, which is accountable to the governing body for the quality of care provided to patients.	**03.00.00 Medical Staff** The organized medical staff that operates under bylaws approved by the governing body is responsible for the quality of medical care provided to patients by the hospital. **03.00.10 Medical Staff Responsibilities to the Governing Body** The medical staff is accountable for the quality of the medical care provided to patients. The medical staff must be well organized in a structure approved by the governing body.	**MS.1 Organized Medical Staff** The medical staff is responsible for the quality of medical care provided to patients by the hospital. **MS.3 Accountability** The medical staff is accountable to the board and is responsible for the quality of the medical care provided to patients.

CHAPTER 5

Oversight of Patient Care, Treatment, Services, and Performance Improvement

OVERSIGHT OF PRACTITIONERS			
CMS	**The Joint Commission**	**HFAP**	**DNV GL**
§482.22 Medical Staff The hospital must have an organized medical staff that operates under bylaws approved by the governing body and that is responsible for the quality of medical care provided to patients by the hospital.	**MS.03.01.01** Licensed independent practitioners (LIP) on the medical staff have responsibility for oversight of the quality of patient care, treatment, and services that are provided by all practitioners who are privileged through the medical staff process. Medical staff oversight functions must be assigned to LIPs who are medical staff members. Practitioners must practice only within the scope of their privileges. The medical staff uses documented processes to provide leadership in activities that relate to patient safety. The medical staff oversees the analysis and improvement of patient satisfaction processes.	**03.00.00 Condition of Participation Medical Staff** The hospital must have an organized medical staff that operates under bylaws approved by the governing body and that is responsible for the quality of medical care provided to patients by the hospital. **03.00.10 Medical Staff Responsibilities to the Governing Body** The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to the patients. The medical staff must be organized in a manner approved by the governing body.	**MS.3 Accountability** The medical staff is responsible for the quality of the medical care provided to patients. Its organization must be approved by the governing body, and it is accountable to the governing body.
COMMENTS/TIPS: In addition to the traditional mechanisms for assessing practitioners, the results of patient satisfaction surveys and review of patient complaints can supply important information regarding the quality of care provided by the medical staff. Summaries of the results of patient surveys can be presented at medical staff meetings. Also, complaints and compliments made by patients regarding care provided by a medical staff member can be included in the medical staff's ongoing evaluation and quality assessment activities. If you work for an organization that is self-insured, you can also request claims reports and licensing board activity to be included at reappointment time.			

PERIODIC APPRAISAL/FOCUSED AND ONGOING PROFESSIONAL PRACTICE EVALUATION/PEER REVIEW			
CMS	**The Joint Commission**	**HFAP**	**DNV GL**
§482.22(a)(1) The medical staff must periodically conduct appraisals of its members. **Interpretive guidelines §482.22(a)(1)** The medical staff must at regular intervals appraise the qualifications of all practitioners who are appointed to the medical staff/granted medical staff privileges. In the absence of a state law that establishes a time frame for periodic reappraisal, a hospital's medical staff must conduct a periodic appraisal of each practitioner. CMS recommends that an appraisal of each practitioner be conducted at least every 24 months. The purpose of the appraisal is to determine the suitability of continuing the medical staff membership or privileges of each individual practitioner, to determine whether that individual practitioner's membership or privileges should be continued, discontinued, revised, or otherwise changed. The medical staff appraisal procedures must evaluate each individual practitioner's qualifications and demonstrated competencies to perform each task or activity within the applicable scope of practice or privileges that he or she has been granted. Components of practitioner qualifications and demonstrated competencies would include at least current work practice, special training, quality of specific work, patient outcomes, education, maintenance of continuing education, adherence to medical staff rules, certifications, appropriate licensure, and currency of compliance with licensure requirements.	**MS.06.01.07** Privileges granted for a period not to exceed two years. **MS.08.01.01 Focused Professional Practitioner Evaluation (FPPE)** The medical staff determines when monitoring and evaluation of a practitioner's professional performance is necessary. All initially requested privileges are subject to a period of FPPE. Criteria is developed by the medical staff to be used in evaluating the performance of practitioners who are credentialed and privileged through the medical staff process whenever a question arises about whether safe, high-quality patient care is being provided. The documented performance monitoring process includes the following: • Criteria to be used for performance monitoring • Method used to establish a monitoring plan that is specific to the privileges being requested • Method used for determining how long the performance monitoring will last • Definition of circumstances requiring monitoring to be conducted by an external source In accordance with criteria and requirements of the medical staff, FPPE must be consistently applied. The medical staff identifies any triggers that would indicate the need for performance monitoring. Decisions to perform FPPE for competence assessment must be based on the evaluation of current clinical competence, practice behavior, and ability to perform the requested privileges.	**03.00.02 Periodic Appraisal** The medical staff must periodically conduct appraisals of its members. Standards are quoted directly from 482.22(a)(1) and the Interpretative Guidelines. **03.15.01 Ongoing Professional Practice Evaluation (OPPE)** OPPE information is factored into decisions regarding maintenance, revisions, and revocation of existing privileges prior to or at the time of renewal. OPPE is applicable to all practitioners with privileges. Data are collected on an ongoing basis and summarized at least three times during each two-year appointment cycle. HFAP recommends distributing data reports to the practitioners. The medical staff determines the data relevant to their practice to be collected for nonphysician practitioners (i.e., NP, PA, CRNA, CNM). The evaluation plan is clearly defined and approved by the medical staff and addresses: • Reasons for OPPE • Performance indicators specific to each medical staff department • Methods for data collection • Those responsible for data collection • Sources of data • How frequently data will be collected • Methods for data evaluation and analysis • Data confidentiality and security • Who may access individual practitioner's data	**MS.12 Clinical Privileges** Appointments or reappointments to the medical staff and the granting, renewal, or revision of clinical privileges are made for a period defined by state law. This cannot exceed three years. SR.4 There shall be a provision in the medical staff bylaws for a mechanism to ensure that all individuals with clinical privileges provide services only within the scope of privileges granted. SR.5 If available, and/or required by the medical staff to hold or maintain clinical privileges, include a review of individual performance data variation from criteria determined by the medical staff to identify need for training or proctoring that may be required.

CHAPTER 6

Medical Staff Involvement in Patient-Focused Areas and Patient Therapeutic Services

ORDERS FOR RESTRAINTS OR SECLUSION AND TRAINING			
CMS	**The Joint Commission**	**HFAP**	**DNV GL**
§482.13(e) Restraint or Seclusion §482.13(e)(5) The use of restraint or seclusion must be in accordance with the order of a physician or other LIP who is responsible for the care of the patient, as specified under §481.12(c), and authorized to order restraint or seclusion by hospital policy in accordance with state law. **Interpretive Guidelines §482.13(e)(5)** Hospitals must have policies and procedures for the initiation of restraint or seclusion that identify the categories of LIPs permitted to order restraint or seclusion in that hospital, consistent with state law. The regulation requires that a physician or other LIP responsible for the care of the patient must order restraint or seclusion prior to the application of restraint or seclusion. In some situations, however, the need for restraint or seclusion may occur so quickly that an order cannot be obtained prior to the application of restraint or seclusion. In these emergency application situations, the order must be obtained either during the emergency application of the restraint or seclusion or immediately (within a few minutes) after the restraint or seclusion has been applied. Failure to immediately obtain an order is viewed as the application of restraint or seclusion without an order. The hospital should address this process in its restraint and seclusion policies and procedures.	If the hospital uses Joint Commission accreditation to meet deemed status, the following requirements must be met: **Restraint and Seclusion** • **PC.03.05.05 Orders** In accordance with hospital policy and law/regulations, orders for restraint or seclusion are given by a physician, clinical psychologist, or other authorized LIP who is primarily responsible for the patient's ongoing care orders. Standing orders or as-needed (PRN) orders are not allowed. • **PC.03.05.09: Policies and Procedures** Hospital policies and procedures regarding restraints include: -Training requirements for staff, physicians, clinical psychologists, or other LIPs -Definition of authority to order restraint and seclusion -Definition of authority to discontinue the use of restraint or seclusion -Definition of who can initiate the use of restraint or seclusion -Definition of circumstances under which restraint or seclusion is discontinued -Requirement that restraint or seclusion is discontinued as soon as possible -Time frames for assessing and monitoring patients in restraint or seclusion -Definition of restraint -Definition of seclusion -Definition or description of what constitutes the use of medications as a restraint	**15.02.10 Orders for Restraint or Seclusion** The use of a restraint/seclusion must be ordered by a physician or other LIP permitted by the state and the hospital to order a restraint. **15.02.11 Use of Standing or PRN Orders** PRN or standing orders are not permitted for orders restraint/seclusion **15.02.18 Physician Training** Training requirements for physicians and other LIPs to order restraint/seclusion must be defined in hospital policy The above standards are directly from the CMS regulation §482.13(e)(5). §482.13(e)(5) The use of restraint or seclusion must be in accordance with the order of a physician or other LIP who is responsible for the care of the patient, as specified under §481.12(c), and authorized to order restraint or seclusion by hospital policy in accordance with state law. §482.13(e)(6) Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN). §482.13(e)(11) Physician and other licensed independent practitioner training requirements must be specified in hospital policy. At a minimum, physicians and other LIPs authorized to order restraint or seclusion by hospital policy in accordance with state law must have a working knowledge of hospital policy regarding the use of restraint or seclusion.	**PR.7 Restraint or Seclusion: Order for Restraint or Seclusion** Restraint or seclusion must be ordered by a physician or other qualified licensed practitioner who is responsible for the care of the patient and is authorized by hospital policy and state law to order restraint or seclusion. An order for restraint or seclusion must be obtained prior to the application of restraints, except in emergency situations when the need for intervention may occur quickly. An order for restraint or seclusion is never to be written as a standing order or on an as needed basis (PRN). Each order for restraint used to ensure the physical safety of the nonviolent or non-self-destructive patient may be renewed, as authorized by hospital policy. **PR.8 Restraint or Seclusion: Staff Training Requirements** Training requirements for physicians and other qualified licensed practitioners must be specified in hospital policies and must be based on the specific needs of the patient population. Physicians and other qualified licensed practitioners who order restraint or seclusion by hospital policy in accordance with state law must have a working knowledge of the hospital policy regarding the use of restraint or seclusion.

ORDERS FOR RESTRAINTS OR SECLUSION AND TRAINING			
CMS	**The Joint Commission**	**HFAP**	**DNV GL**
The policies and procedures should specify who can initiate the emergency application of restraint or seclusion prior to obtaining an order from a physician or other LIP. For the purpose of ordering restraint or seclusion, an LIP is any practitioner permitted by state law and hospital policy to have the authority to independently order restraint or seclusion for patients. A resident who is authorized by state law and the hospital's residency program to practice as a physician can carry out functions reserved for a physician or LIP by the regulation. A medical school student holds no license, and his/her work is reviewed and must be countersigned by the attending physician; therefore, he or she is not licensed or independent. A medical school student is not an LIP. A protocol cannot serve as a substitute for obtaining a physician's or other LIP's order prior to initiating each episode of restraint or seclusion use. If a hospital uses protocols that include the use of restraint or seclusion, a specific physician or LIP order is still required for each episode of restraint or seclusion use. **§482.13(f) Standard: Restraint or Seclusion: Staff Training Requirements** The patient has the right to safe implementation of restraint or seclusion by trained staff.	42 *CFR* 82.13(e)(1) §482.13(e) (1) Definitions. (i) A restraint is— (A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely 42 *CFR* 82.13(e)(1)(i)(C) §482.13(e)(1)(i)(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort). For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's definition of seclusion is in accordance with: 42 *CFR* 82.13(e)(1)(ii) Those ordering restraint or seclusion are familiar with the hospital's restraint and seclusion policies.		

FIGURE 6.1: SAMPLE POLICY AND PROCEDURE FOR OUTPATIENT ORDERS (CONT.)

3. Complete the Outpatient Services New Practitioner Verification form (Attachment A) to document completion of the verifications. Enter the following information into [insert name of hospital billing system, Meditech, etc.].

   A. Practitioner's full legal name and credentials (MD, DO, PA, DC, DDS, DMD, etc.) [include all practitioners allowed to order]
   B. Office address, phone, and fax number
   C. Specialty
   D. Current state medical license number
   E. NPI number
   F. [List others, as appropriate per facility policy]

RESPONSIBILITY

1. Each director of a department that provides outpatient tests or services is responsible for ensuring that all individuals adhere to the requirements of this policy, that these procedures are implemented and followed, and that instances of noncompliance are reported to the compliance officer.

Attachment A
Outpatient services new practitioner verification form

_____ _____ _____

LAST NAME FIRST NAME CREDENTIAL

Practitioner's full legal name and credentials (MD, DO, PA, DC, DDS, DMD, etc.)

OFFICE ADDRESS: _____

_____

OFFICE PHONE: _____

1. LICENSE VERIFICATION

   State of Licensure _____ License number_____

   Date verified _____

   Active? ☐ Yes ☐ No (If no, refer to Medical Staff Services)

2. OIG VERIFICATION

   Date verified _____

   Excluded? ☐ Yes ☐ No

3. NATIONAL PROVIDER IDENTIFIER (NPI)

   Date verified _____

   Number _____

   _____
   Name of Person Performing Verifications

   _____
   Signature of Person Performing Verifications

Submit completed form to [name/department]

SECTION 3

Ambulatory Care: Credentialing Standards

Ambulatory Care Overview

Section 1 of *Verify and Comply* outlines the credentialing standards for acute care and health plans. The requirements for CMS, The Joint Commission, HFAP, DNV, and NCQA are delineated.

Section 3 outlines the credentialing standards for ambulatory care and ambulatory surgical facilities. Chapter 7 outlines the requirements for initial appointment/initial clinical privileges and recredentialing/renewal of privileges. Chapter 8 identifies other credentialing aspects.

The CMS regulations and ambulatory standards of two accrediting agencies are presented—The Joint Commission (TJC) and the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC). As in Section 1, the standards are presented by element of verification. Each accreditor's requirements are identified on each page. This allows an at-a-glance comparison of the standards of both organizations.

The CMS regulations are from the *State Operations Manual* Appendix L—Guidance for Surveyors: Ambulatory Surgical Centers Rev. 137, 04-01-15, which is the most current revision as of the date of publication. CMS has reported updates to Appendix L should be released in the Spring of 2020.

The standards of The Joint Commission are from the 2020 e-edition of the *Comprehensive Accreditation Manual for Ambulatory Care* (2020 update).

According to The Joint Commission, ambulatory care accreditation covers the following healthcare organizations:

- Ambulatory surgery centers
- Community health centers
- Group practices
- Imaging centers/mobile imaging
- Sleep labs
- Rehabilitation centers
- Telehealth providers
- Student health centers
- Urgent care clinics
- Convenient care clinics
- Correctional healthcare

CHAPTER 7

Ambulatory Care: Initial Appointment, Clinical Privileges, and Credentialing

PRACTITIONERS COVERED		
CMS	**The Joint Commission (Ambulatory)**	**Accreditation Association for Ambulatory Health Care (AAAHC)**
§416.42 Surgical Services Surgical procedures must be performed in a safe manner by qualified physicians who have been granted clinical privileges by the governing body of the ASC in accordance with approved policies and procedures of the ASC. **Interpretive Guidelines: §416.42** Qualified Physician: Surgery in an ASC may only be performed by a qualified physician. With respect to ASCs, a physician is defined in accordance with §1861(r) of the Social Security Act to include a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, and a doctor of podiatric medicine. In all cases, the physician must be licensed in the state in which the ASC is located and practicing within the scope of his/her license. In addition, the regulation requires that each physician who performs surgery in the ASC has been determined to be qualified and granted privileges for the specific surgical procedures he/she performs in the ASC. The ASC's governing body is responsible for reviewing the qualifications of all physicians who have been recommended by qualified medical personnel and granting surgical privileges as the governing body determines appropriate. The ASC must have written policies and procedures that address the criteria for clinical staff privileges in the ASC and the process that the governing body uses when reviewing physician credentials and determining whether to grant privileges and the scope of the privileges for each physician. **§416.45(c) Other Practitioners** If the ASC assigns patient care responsibilities to practitioners other than physicians, it must have established policies and procedures, approved by the governing body, for overseeing and evaluating their clinical activities.	**HR.02.01.03 Clinical Privileges** **Licensed independent practitioners (LIP):** All practitioners who are permitted by law and by the organization to practice independently are granted clinical privileges. This standard is additionally required for an ASC participating in the Medicare deemed status survey: The governing body grants clinical privileges to physicians who perform surgery. **HR.01.02.01 Qualifications** **Nonlicensed independent practitioners:** The organization assesses the qualifications and competence of a nonemployee individual brought into the organization by an LIP prior to providing care, treatment, or services. It is expected that the individual's qualifications and competence will be the same as the qualifications and competence required if the individual were to be employed by the organization to perform the same or similar services. The assessment/confirmation can be done through the organization's regular process or by the LIP who brought in the individual. When the service to be provided by the individual is not currently performed by anyone employed by the organization, it is leadership's responsibility to consult the appropriate professional organization guidelines with respect to requirements for credentials and competence. *Note: The Joint Commission ambulatory care standards are silent on credentialing and privileging for PAs and APRNs, who are not LIPs.* *However, a Joint Commission Standards BoosterPak™ for Focused Professional Practice Evaluation/Ongoing Professional Practice Evaluation includes information stating that if an APRN or PA is providing a medical level of care (making medical diagnosis and medical treatment decisions), the individual should be privileged.* *Additional guidance is available in the BoosterPak™.*	**Governance—Subchapter II—Credentialing and Privileging** The organization establishes minimum training, experience, and other requirements (i.e., credentials) for physicians and other healthcare professionals. (Medicare Deemed Status 416.45) **2.II.B -** The governing body (consistent with state law) appoints, reappoints, and assigns and/or curtails clinical privileges of medical staff members based on professional peer evaluation. (Medicare Deemed Status 416.45(a)) **2.II.F -** The governing body provides a process (consistent with state law and evidence of education, training, experience, and current competence) for initial appointment, reappointment, and assignment and/or curtailment of privileges and practice for allied health professionals. The governing body determines if other categories with patient care responsibilities besides advanced practice nurses and physician assistants are included in the Allied Health professional category. (Medicare Deemed Status 416.45(c)) **2.II.G -** If patient care responsibilities are assigned to practitioners other than physicians, the organization must have established policies and procedure for overseeing and evaluating these practitioners' clinical activities. The policies and procedures must be approved by the governing body. (Medicare Deemed Status 416.45(c)) **Surgical and Related Services** **10.1.C** Surgical procedures must be performed in a safe manner only by qualified providers who are licensed to perform such procedures within the state in which the organization is located and have been granted clinical privileges to perform those procedures by the governing body. (Medicare Deemed Status 416.42) The standards do not further define the practitioners covered. Glossary definitions are: • Physician: A person who has been educated, trained, and licensed to practice the art and science of medicine. The term "physician" includes professionals who have earned MD, DO, DDS, DMD, or DPM degrees. • Healthcare professional: Any individual who provides health services to a patient.

FIGURE 7.1: SAMPLE POLICY AND PROCEDURE FOR VERIFICATION OF IDENTITY

Policy:

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

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

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

Procedure:

Verification can be conducted during any of the following processes:

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

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

Attachment A: Verification of identity documentation form

Practitioner name (please print): _____

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

_ Military picture ID

_ Passport

_ State driver's license or ID _____

[List issuing state]

Signature of person verifying

_____

Date

_____

Printed name of person verifying

_____

CHAPTER 8

Ambulatory Care: Other Credentialing Aspects

DISASTER PRIVILEGES		
CMS	**The Joint Commission (Ambulatory)**	**Accreditation Association for Ambulatory Health Care (AAAHC)**
§416.41(c)(1) Disaster Preparedness Plan (1) The ASC must maintain a written disaster preparedness plan that provides for the emergency care of patients, staff, and others in the facility in the event of fire, natural disaster, functional failure of equipment, or other unexpected events or circumstances that are likely to threaten the health and safety of those in the ASC. (2) The ASC coordinates the plan with state and local authorities, as appropriate. (3) The ASC conducts drills, at least annually, to test the plan's effectiveness. The ASC must complete a written evaluation of each drill and promptly implement any corrections to the plan.	**EM.02.01.01—Emergency Management Plan** The organization has a written Emergency Management Plan. **EM.02.02.13 Volunteer LIPs** When the emergency management plan has been activated and the organization is unable to handle the immediate patient needs, disaster privileges may be granted to volunteer LIPs. The organization identifies the individual(s) responsible to do so. Appropriate policies and procedures define a mechanism for overseeing the professional performance of the LIP with disaster privileges, along with a mechanism for identifying the volunteer LIP easily. Disaster privileges may be granted to LIPs upon presentation of a valid government-issued photo ID, such as a driver's license or passport, and at least one of the following: • Current healthcare organization picture ID card that identifies the LIP's professional discipline • Current license to practice* • Primary source verification of the license • Identification indicating the practitioner is a member of a Disaster Medical Assistance Team (DMAT), Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal group • Identification indicating the practitioner has been given the authority by a government entity to provide clinical care during a disaster • Affirmation by an LIP currently privileged by the organization or by a staff member with personal knowledge of the individual's ability to act as an LIP during a disaster Primary source verification of licensures begins as soon as the immediate situation is under control or within 72 hours** of the practitioner presenting to the organization	**Infection Prevention and Control and Safety** **8.H -** There is a written emergency and disaster preparedness plan addressing internal and external emergencies, including participating in community health emergency or disaster preparedness, when applicable. The plan includes a provision for the safe evacuation of individuals during an emergency, particularly individuals who are at greater risk. The following standards are additionally required for an ASC participating in the Medicare deemed status survey. **Governing Body—General Requirements** **I.G -** The governing body has oversight and accountability for developing and maintaining a disaster preparedness plan. (Medicare Deemed Status 416.41) **Infection Prevention and Control and Safety** **8.II -** The ambulatory surgery center (ASC) must maintain a written disaster preparedness plan that provides for the emergency care of patients, staff, and others in the facility in the event of fire, natural disaster, functional failure of equipment, or other unexpected events or circumstances that are likely to threaten the health and safety of those in the ASC. The ASC does the following: • Coordinates this plan with state and local authorities, as appropriate • Conducts drills, at least annually, to test the plan's effectiveness • Completes a written evaluation of each drill and promptly implements any corrections to the plan (Medicare Deemed Status 416.54)

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

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