MEDICAL RESOURCE CENTER FOR RANDOLPH COUNTY, INC.
POLICY & PROCEDURES

MANUAL: Human Resources	**SUBJECT: Credentialing & Privileging of Licensed and Certified Practitioners**
NUMBER:	**PAGE: 1 OF: 12**
EFFECTIVE DATE:	**SUPERSEDES:**
ADOPTED FROM: NACHC **REVIEWED BY: Executive Team, Board of Directors**	**DATES OF REVISION:**
APPROVED: July 21, 2011	**DATES OF REVIEW: July 21, 2011**

1. POLICY:

This policy applies to all Licensed Independent Practitioners (LIP) and Other Licensed or Certified Practitioners (OLCP) who are permitted by law and who would provide direct patient care at ----------and who are utilized on a full-time, part-time, intermittent, consultant, locum tenens or volunteer basis.

----------'s credentialing and privileging process is intended to protect its patients by ensuring that its providers possess requisite training, experience, and competence. Consequently, ----------requires primary source documentation of a provider's license to practice, graduation from the appropriate school / program, and DEA certification. In addition, ---------- verifies all providers' employment history, references, malpractice history, and compliance with Federal and State fraud and abuse laws.

---------- requires that providers cooperate in the credentialing and privileging process. Providers' failure to comply with credentialing and privileging or submit the necessary documentation may result in disciplinary action, up to and including termination.

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II. PROCEDURE:

1. Credentialing and Privileging

A. Each LIP must undergo credentialing and privileging, and the delineation of clinical privileges must be practitioner-specific and site-specific.

B. A candidate seeking credentialing must complete the Credentialing and Privileging Application and appropriate privileging request form(s) for the position for which he or she is applying. Applicants are required to provide all requested information and documentation and must sign the "Consent and Release" form.

C. Information obtained to be used in the credentialing process must be primary source verified (unless otherwise noted) and documented in writing, either by letter, internet verification printout or report of contact. All efforts (and failures) to obtain required documents should be documented in the file.

D. If a decision is made to use a Credential Verification Organization ("CVO"), the CVO must use equivalent standards to those outlined in this policy, and the agreement with the CVO must specify such details.

E. Applicants being credentialed in preparation for applying for clinical privileges must possess at least one current and unrestricted license in the appropriate jurisdiction to be eligible.

F. Applicants whose professions or occupations are addressed by the National Practitioner Data Bank ("NPDB") will be properly screened:
   1. Prior to credentialing, including reappraisal;
   2. Every two years following initial credentialing or reappraisal; and
   3. Any time a clinical privilege application is made, including additional privileges after the original NPDB query.

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G. Practitioners requesting clinical privileges must provide at least three references including at least one from the current or most recent employer(s) or institution(s) where the applicant holds or held privileges and one from someone who has supervised the practitioner's clinical practice. All references must be documented in writing.

H. Clinical privileges must be based on evidence of an individual's current competence. When privilege delineation is based primarily on experience, the individual's credentials record must reflect that experience, and the documentation must include the numbers, types, and, as available, outcomes of related cases.

I. The exercise of clinical privileges will be subject to the policies and procedures of ---------and the authority of the Chief Medical Director ("CMD") and the Chief Dental Director ("CDD").

J. General criteria for privileging will be uniformly applied to all applicants. Such criteria must include, at least:

1. Evidence of current unrestricted licensure; Relevant training and/or experience;

2. Current competence and health status (as it relates to the individual's ability to perform the requested clinical privileges). All applicants and current clinicians who request clinical privileges will be required to certify a declaration of appropriate health status. If an applicant reports that he or she has a physical or mental condition that could affect his or her ability to exercise the clinical privileges requested or that would require an accommodation for him or her to practice safely, and he or she is found to be professionally qualified for the clinical privileges requested, he or she will be given an opportunity to meet with the CMD/CDD prior to the final decision of the CEO or their designee to determine what accommodations are necessary or feasible to allow him or her to practice safely; and

3. Consideration of any information related to malpractice allegations or judgments, loss of medical staff membership, loss and/or reduction of clinical privileges, or challenges to licensure. Applicants are required to give detailed written explanations of any involvement in administrative, professional, or judicial proceedings in which malpractice is or was alleged. If an applicant has been involved in such proceedings, a full evaluation of the circumstances will be made by the CMD/CDD (and General Counsel, if needed) prior to making any recommendation or decision on the candidate's suitability for employment at----------.

K. Applicants completing application forms will be required to respond to questions concerning clinical privileges at other healthcare institutions. Verification of clinical privileges currently, or most recently, held at other institutions will be obtained and documented in writing in the Credentialing and Privileging files. The verification should indicate whether the privileges are (or were) in good

standing with no adverse actions or reductions for the specified period of time.

Only practitioners who are licensed and permitted by law and MERCE to practice independently may be granted clinical privileges. Privileges will be granted according to the procedures delineated in this policy.

L. Only privileges for procedures, treatments or methodologies actually provided by ---------- may be granted to a practitioner. One standard of care must be observed regardless of practitioner, service or location within ----------

M. Clinical privileges are granted for a period not to exceed two years. Clinical privileges are not to be extended beyond the two-year period, which begins from the date the privileges are signed, dated, and approved by the Board of Directors.

N. Applicants for privileges will be kept apprised of the status of their application and involved in clarification of issues, as appropriate.

O. The process of credentialing and granting clinical privileges for the CMD/CDD will be the same as outlined in the preceding paragraphs. The CMD's and CDD's request for privileges will be reviewed, and a recommendation made, by a senior clinician.

P. The credentialing process must be completed prior to the granting of privileges and the initiation of independent practice, as well as periodically, as required, to continue independent practice, except as identified in Section 3 entitled "Temporary Independent Practice in Emergency Situations."

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2. Responsibility for the Credentialing and Privileging Process

A. The CEO or their designee shall be responsible for reviewing the recommendations of the Chief Medical Director ("CMD") and the Chief Dental Director ("CDD") making recommendations to the Board of Directors of candidates it deems qualified to practice independently at ----------.Recommendations from the CEO or their designee will be forwarded to the Board of Director Personnel/Nominations Committee (BDPNC) for action.

B. The CMD/CDD is responsible for first reviewing the contents of the credentialing and privileging file for each candidate and then evaluating the Request for Privileges. The CMD/CDD is to document the results of the review and make a recommendation regarding approval of privileges to the CEO or their designee.

C. The BD will review all credentialing and privileging applications referred by the CEO or their designee and will follow the same rules as the CEO or their designee.

D. The Board of Directors is ultimately responsible for the credentialing and privileging of staff at ----------. The Board of Directors, based on recommendations from the CEO and other appropriate staff takes final action on the credentialing and privileging of LIP staff.

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3. Temporary Independent Practice in Emergency Situations

When there is an emergent or urgent patient care need, permission to practice independently on a temporary basis may be made by the CMD/CDD prior to receipt of references or verification of other information and action by the CEO or their designee.

A. Evidence of current licensure verification, confirmation of possession of appropriate clinical privileges at another healthcare facility and a reference will be obtained prior to the granting of such permission.

B. The CMD/CDD must document for the record the specific patient care situation that warranted the granting of temporary privileges and inform and give the rationale to the CEO or their designee for the granting of temporary privileges. The CEO or their designee can rescind the granting of temporary privileges.

C. Temporary privileges should not exceed 30 days.

D. Granting of permission to practice independently on a temporary basis is for emergent patient care only and NOT to be used for administrative convenience.

4. Modification of Privileges

A. Practitioners may submit a request for modification of clinical privileges at any time. Requests to add or modify privileges must be accompanied by the appropriate documentation that supports the practitioner's assertion of competence (i.e., advanced educational or clinical practice program, clinical practice information from other institution(s), references, etc.) Requests for modification of privileges will be processed in the same manner as initial privileges.

____may choose, due to changes in mission and/or clinical techniques over time, to change the scope of clinical privileges it is willing to grant. Issues such as lack of demand to perform operations and/or procedures in sufficient number of frequency to maintain clinical competence in accordance with facility established criteria, or failure to use privileges previously granted, will affect the CMD/CDD for the granting of privileges. These actions will be considered changes and will not be construed as a reduction, restriction, loss, or revocation of clinical privileges. Such changes will be discussed between the CMD/CDD and the affected practitioner.

5. Biennial Reappraisal (Re-Credentialing and Re-Privileging)

A. At least every two years, each LIP must be reappraised to determine whether or not he or she continues to have the credentials and competence to be privileged to practice as an independent practitioner at MERCE. Requests for re-privileging will be processed in the same manner as initial privileges.

B. Evaluation of professional performance, judgment, and clinical and/or technical competence and skills will include:

1. Self-reported information from the reappraisal application, including:

- Information regarding the status of clinical privileges (including limitation, reduction or loss (voluntary or involuntary) of privileges) held at other institutions (if applicable);
- Loss of medical staff membership;
- Revision or loss of privileges;
- Pending malpractice claims or malpractice claims closed since last reappraisal or initial credentialing;

- Mental and physical status (as it relates to the ability to perform the requested clinical privileges);
- Continuing medical education, dental continuing education, and continuing education unit accomplishments, and any other reasonable indicators of continuing qualifications.

2. Peer recommendations. A minimum of two peer recommendations will be required. The peers must have acquired the requisite knowledge through observation of the practitioner's professional practice over a reasonable amount of time to be able to address current competence in all areas of requested privileges.
3. Results of provider-specific performance improvement activities. For medical and dental staff, the reappraisal process will include consideration of such factors as the number of procedures performed or major diagnoses treated, rates of complications compared with those of others doing similar procedures and adverse results indicating patterns or trends in a practitioner's clinical practice.

C. The CMD/CDD must document (list documents reviewed and the rationale for conclusions reached) that the results of the quality of care activities have been considered in recommending the individual privileges. Upon completion of this assessment, the CMD/CDD will make a recommendation as to the practitioner's request for clinical privileges.

D. The process for the renewal of clinical privileges should be initiated no later than three months prior to the date the privileges expire. It is the responsibility of ----and the practitioner to ensure that privileges are reviewed and renewed by the expiration date in order to prevent a lapse in the practitioner's authority to treat patients.

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E. The process of reappraisal and granting new clinical privileges for CMD/CDD will be the same as outlined in the preceding paragraphs. The CMD's/CDD's request for privileges will be reviewed, and a recommendation made, by a senior clinician.

Definitions:

1. Credentialing. Credentialing refers to the systematic process of screening and evaluating qualifications and other credentials, including Licensure, required education, relevant training and experience, current competence and health status (as it relates to the practitioner's ability to perform job responsibilities). Credentialing (and corresponding Clinical Privileging) must be jurisdictional and facility specific.

2. Licensure. Licensure refers to the official or legal permission to practice in an occupation, as evidenced by documentation issued by a State in the form of a license or registration.

3. Clinical Privileging. Clinical Privileging is defined as the process by which a licensed for independent practice (i.e., without supervision, direction, required sponsor, preceptor, mandatory collaboration, etc.) is permitted by law and MERCE to practice independently, to provide medical or other patient care services within the scope of the individual's license, based on the individual's clinical competence as determined by peer references, professional experience, health status, education, training, and Licensure. Clinical privileging must be provider specific.

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4. Licensed Independent Practitioner ("LIP"). LIP includes any individual permitted by law (the statute which defines the terms and conditions of the practitioner's license) and the facility to provide patient care services independently (i.e., without supervision or direction) within the scope of the individual's license and in accordance with individually granted clinical privileges. Only licensed independent practitioners may be granted clinical privileges. LIPs include, but are not limited to physicians, dentists, nurse practitioners, nurse midwives, and any other individual. For purposes of this policy, physician assistants, nurse practitioners and certified nurse midwives are considered LIPs even though their ability to practice independently varies, in some cases by jurisdiction.

5. Other Licensed or Certified Health Care Practitioner ("OLCP"). OLCPs include individuals who are licensed, registered or certified but are not permitted by law to provide patient care services without direction and supervision. They include laboratory technicians, social workers, medical assistants, licensed practical nurses, and dental hygienists. These individuals must also be credentialed but not necessarily in accordance with the strict standards applicable to LIPs.

6. Primary Source Verification. A process through which an organization validates credentialing information from the organization that originally conferred or issued the credentialing element to the practitioner.

7. Secondary Source Verification. A process through which an organization documents credentialing information through written material (e.g., copy of license or transcript) that is not considered primary source material.

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This Policy and Procedure shall be reviewed periodically and updated consistent with the requirements established by the Board of Directors,_____'s senior management, Federal and State law and regulations, and applicable accrediting and review organizations.

Responsible Parties:

Signature **Date**
Board Chair

Signature **Date**
CEO

Signature **Date**
Chief Medical Director

Signature **Date**
Chief Dental Director

Signature **Date**
HR Director