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Children's Hospital & Medical Center

Nebraska Association
Medical Staff Services

NEBRASKA ASSOCIATION MEDICAL STAFF SERVICES

Who are we?

- State Association within the National Association Medical Staff Services
- Established in 1983 to provide a network for Medical Staff Professionals for education and advocacy
- Composed of MSPs throughout the State from hospitals, clinics, long term care and rehab facilities and managed care organizations.
    - Credentialing Specialists
    - Nurses
    - Quality Coordinators
    - Administrators
    - Payor Enrollment Specialists

Who am I?

- Director, Medical Staff Services – Children's Hospital & Medical Center
  - Oversight of Medical Staff Credentialing
  - Oversight of Payor Enrollment & Credentialing
- Medical Services Professional with over 15 years of healthcare experience
- Certified Professional Medical Services Management (CPMSM)
- Certified Provider Credentialing Specialist (CPCS)

PRE-READ DOCUMENTS

- Core Privilege List Example
- Credentialing Policies & Procedures Manual
- Credentialing by Proxy Guidebook
- Laundry List Privilege List Example
- Sample Application
- Sample Consent Form
- Sample File Checklist
- Sample FPPE Chart Review Form
- Sample OPPE Questionnaire
- Sample OPPE Report
- Sample Reference Questionnaire

Credentialing and Privileging

CREDENTIALING

Definition: Credentialing is the process of verifying the qualifications of licensed medical professionals to ensure they are properly trained, certified, and experienced to provide healthcare services to patients.

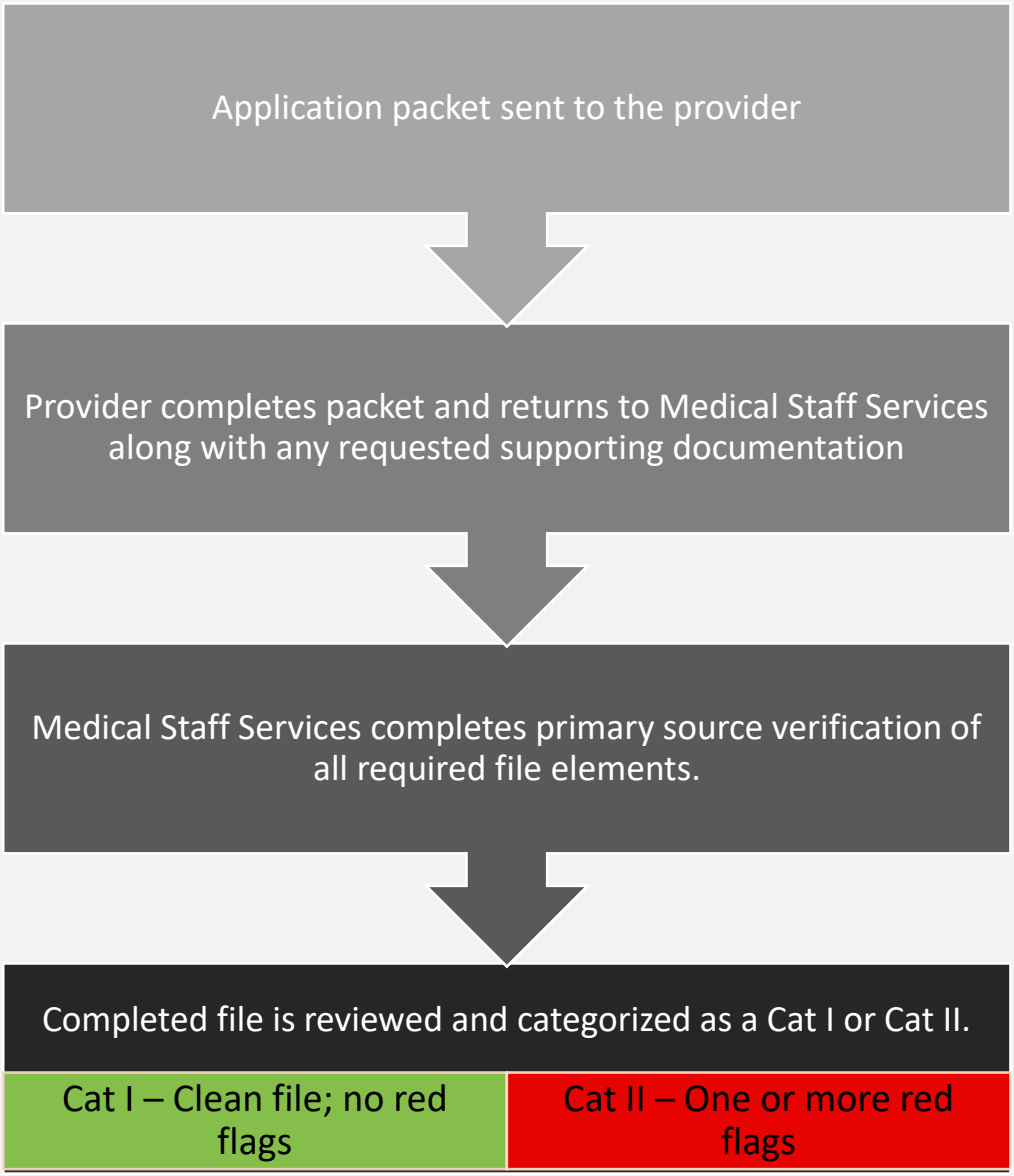
FOUR TYPES OF CREDENTIALING

- Medical Staff Credentialing
- Payor Credentialing
- Delegated Credentialing
- Credentialing by Proxy

MEDICAL STAFF CREDENTIALING

- Pre-Application/Interview
- Initial Application
- Recredentialing Application
- **Primary Source Verification**
  - In-house
  - CVO
- **Credentialing File Review**
- Committee/Governing Body Approval
- Audits/Oversight
  - TJC
  - DNV
  - HFAP
  - AAAHC
  - CMS
  - DHHS

Initial & Reappointment Application Process



- Peer references and/or prior affiliations indicate potential problems (e.g., difficulty with interpersonal relationships, patient care issues, etc.).
- There are discrepancies between information the applicant submitted, and information received from other sources that cannot be reconciled.
- Privileges the applicant requested are outside of the scope of privileges for their specialty.
- There are gaps in time for which the applicant has not accounted.
- Disciplinary actions have been taken by a state licensing board or a state or federal regulatory agency, or there has been a criminal conviction of a felony or misdemeanor for any offense related to professional practice, health care related matters, third-party reimbursement, acts of assault, battery, or any manner of violence against another person, use, abuse, or possession of any controlled substance, or operating a motor vehicle while impaired by alcohol or a controlled substance.
- The applicant has experienced voluntary or involuntary termination of medical staff membership, or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another health care organization.
- The applicant has experienced removal from a provider panel of a managed care entity for reasons of unprofessional conduct or quality-of-care issues.
- The applicant has been the subject of malpractice claims/settlements/judgments.
- The applicant has had multiple healthcare organization affiliations in multiple areas during the past two years without reasonable justification, i.e. working as a locum tenens;
- The applicant has not met the continuing medical education requirements set forth in the Medical Staff Documents.

*If the Department Chair's findings are negative or differ from that of the Credentials Committee Chair or Medical Staff President, the application is automatically classified as Category II and processed accordingly.

WHAT MAKES A FILE A CATEGORY II?

What is Primary Source Verification?

The Joint Commission defines primary source verification as:

“Verification of an individual practitioner’s reported qualifications by the original source or an approved agent of that source. Methods for conducting primary source verification of credentials include direct correspondence, documented telephone verification, secure electronic verification from the original qualification source, or reports from credentials verification organizations (CVOs) that meet Joint Commission requirements.”

Credentialing File Review
Six Step Process

Credentialing Specialist completes initial checklist and signs-off on file

Director, Medical Staff Services completes second-set-of-eyes review and sign-off on file

Department Chair completes file review in Committee Manger and signs-off on file

APP reviewer completes file review in Committee Manger and signs-off on file (if applicable)

File is reviewed by the Credentials Committee

File is reviewed by the Medical Executive Committee

File is reviewed by the Quality & Patient Safety Committee of the Board

CREDENTIALING FILE ITEMS VERIFIED THROUGH THE PRIMARY SOURCE

- Background Check
- Board Certification (if applicable)
- Controlled Substance Registration (if applicable)
- DEA (if applicable)
- ECFMG (if applicable)
- Education/Training
- License
- Malpractice Claims History
- Malpractice Liability Insurance Coverage
- Medicaid/Medicare Sanctions
- Nebraska Medicaid ID Number
- National Practitioner Data Bank (NDPB)
- National Provider Identification (NPI) Number
- Office of Inspector General (OIG) Exclusion List
- Peer References
- System for Award Management (SAM) Search
- State Sanctions Search
- Verification of Hospital Privileges and Affiliations
- Verification of ID
- Work History

PAYOR CREDENTIALING

- Enrollment Request
- Initial credentialing
- Recredentialing
- Primary Source Verification
- Committee/Governing Body Approval
- Audit/Oversight
  - NCQA
  - URAC
  - CMS
  - DHHS

DELEGATED CREDENTIALING

- Medical Staff/Payor Credentialing
  - Alignment of two departments/processes
  - Processes run in parallel
  - Significantly reduces time from credentialed provider to billing provider
- Requires Compliance w/ Regulations From Multiple Accrediting Bodies – TJC, NCQA, URAC, CMS, & DHHS
- Contract Required
- Initial Assessment
- Annual/Triannual Audit
- DHHS Audit
- Roster Submission

CREDENTIALING BY PROXY

- Medical Staff/Telemedicine Credentialing
- Originating Site vs. Distant Site
- Allowed by CMS
- TJC to TJC
- Requires Addendum to TSA
- Modified or Full

*For telehealth services the provider must be licensed in the state the patient is located.

*For payors, the provider must also have a DEA in that state.

PRIVILEGING

Definition: Privileging is the process of delineating the scope of practice for a provider within your organization, as well as any procedural privileges they are authorized to perform.

- Completed w/ Initial Credentialing
  - FPPE
- Privilege Modification
  - FPPE
- Demonstration of Competency at Reappointment
  - OPPE
  - Privilege Relinquishment
- **Core** vs. **Laundry List**
- Criteria-based
- New Privileges/Procedures
- Telemedicine Privileges
- APP Privileges
- Temporary Privileges
- Emergency Privileges
- Disaster Privileges

Staff Category Examples

- **Applicant** – individuals who have applied for membership and/or privileges but whose application is not yet complete or approved

Privileged Provider Types

- **Advanced Practice Provider** – privileged provider. Non-physician or dentist. May not admit patients. Scope of practice is defined by privilege delineation.
- **Active Admitting** – privileged provider. May admit, consult, etc. Only limitations are those as delineated by or notated in privileges
- **Active Consulting** – privileged provider. May only consult, order tests, perform procedures, etc. May not admit patients.
- **Active Pediatric Consult Required** – privileged provider. May only provide services to patients with the consultation of a pediatrician
- **Ambulatory Proceduralist** – privileged provider. May only see patients and perform procedures at COSC. May not admit patients.

Non-Privileged Provider Types

- **Active, No Privileges** – non-privileged provider. Active Medical Staff only. May not provide inpatient services in any capacity (Also majority of Children's Physicians providers)
- **Affiliate** – non-privileged provider. Only has Medical Staff affiliation. Majority are retired providers.
- **Honorary** – non-privileged provider. Provider has resigned and been granted Honorary status due to a significant contribution they have made to CHMC and Pediatric healthcare.

QUESTIONS?

BREAK

PEER REVIEW

Peer Review

- FPPE
- OPPE/Provider Scorecard
- Peer Review Committee
- Internal vs. External Peer Review

FPPE
What is it?

- Focused Professional Practice Evaluation
- Required by The Joint Commission (MS.08.01.01)
- Defined by the Organized Medical Staff
- Completed by a delegated proctor
- **Can be retrospective, concurrent, or prospective**
- May obtain external FPPE for low volume providers

FPPE WHEN IS IT REQUIRED?

- FPPE for the initial granting of privileges
  - New providers and addition of new privilege for existing providers
- FPPE for cause - Issues arise affecting safe, high-quality care
  - Incident Report
  - Inability to Meet Performance Expectations
    - OPPE
    - Track and trend report
    - Provider behavior policy

FPPE FOR NEW PRIVILEGES HOW TO IMPLEMENT?

- Develop Policy
  - Standard FPPE
    - Assigned proctor
    - Number and type of review
    - Timeframe for completion – ideally w/in 90 days
  - Low/No Volume
    - External FPPE
    - Extended FPPE
    - Limited FPPE
  - Department Chair Review
  - Credentials Committee/MEC Review

FPPE FOR CAUSE
HOW TO IMPLEMENT?

- Develop Policy
  - Medical Staff identify triggers that would necessitate a return to FPPE
  - Determine Performance Monitoring Process
    - Criteria
    - Method to establish monitoring plan
    - Method to determine duration of monitoring
    - Situations requiring external review
    - Medical Executive Committee
  - Duration/Limitations
    - Reportable?

FPPE
WHO PERFORMS THE EVALUATION?

Definition of Peer

- A peer is an individual practicing in the same profession and who has expertise in the subject matter under evaluation. The level of subject matter expertise required to provide meaningful evaluation of a provider's performance will be based on the area of competency and the nature of the issue or data being evaluated.

(Effective Peer Review, Second Edition)

FPPE
WHO PERFORMS THE EVALUATION?

- Same Discipline
  - Same specialty should be used if what is being evaluated requires the reviewer to have skills specific to that specialty or procedure
- Supervising Physician/APP
- Must be Objective and Impartial
  - No potential conflict of interest
  - No bias toward physician
- External FPPE may be obtained for low volume providers or for new privilege to the organization

OPPE
What is it?

- Ongoing Professional Practice Evaluation
- Required by The Joint Commission (MS.08.01.03)
- Required by NCQA and URAC (Quality report)
- Measures the performance of providers with clinical privileges at your organization
- May be utilized for performance improvement activities
  - Root Cause Analysis (RCA)/Identify systems issues
  - Reduction of HACs and SSIs
  - Reduction in morbidity and mortality
- Used for evaluation during credentialing process (reappointment)
- Track and trend
- Sometimes called a Physician Scorecard

OPPE
WHAT TO REVIEW?

- Six Core Competencies (TJC)
  - Patient Care
  - Medical Knowledge
  - Practice-based Learning and Improvement
  - Interpersonal and Communication Skills
  - Professionalism
  - Systems-Based Practice
- Determined by the Organized Medical Staff
  - Possible Metrics
    - Review of Operative/Clinical Procedures
    - Blood or Pharmaceutical Usage
    - Length of Stay/Readmission Data
    - Morbidity and Mortality Data
    - Infection Control Data
    - Professionalism/Patient Experience Data
    - Specialty Specific Data

OPPE
HOW TO OBTAIN?

May acquire data through:

- Chart Review
- Direct Observation
- **Peer Evaluations**
- Patient Surveys
- Monitoring
  - Blood Bank or Pharmacy
  - Health Information Management
  - Incident Reports
  - Quality Department
- **Automate reports whenever possible**

OPPE Reporting and Review?

- Determined by Medical Staff Policy
  - Staff/Supervisor Review
  - Frequency
  - Variance Monitoring
- Intent is to review on an ongoing basis
- Should be meaningful and not just checking a box
- TJC requires reporting at least every 12 months
- TJC requires review with recredentialing every 2 years
- Payors require review every 3 years for recredentialing

OPPE WHAT IF CONCERNS?

Follow your policy

- Report findings to your medical staff peer review body
- Evaluate need to place on FPPE
- Determine need to evaluate provider privileges – continue, limit or revoke
  - Limitation or Revocation may involve an Investigation and would allow Hearing Rights

FPPE/OPPE MAINTENANCE

- Review Measures/Criteria Routinely
  - Gather information from Medical Staff and departments collecting data
  - Validate data periodically
  - Identify stagnant data and replace if necessary
- Evaluate current process viability

QUESTIONS?

PEER REVIEW COMMITTEE

PROVIDER QUALITY COMMITTEE (PQC)
PROFESSIONAL PRACTICE EVALUATION COMMITTEE (PPEC)

- Committee composed of peers
  - Voting members
  - Ex-officio (non-voting) members
- Representation from a wide variety of specialties
- Responsible for reviewing and improving the quality of patient care, treatment, and services provided
- Non-biased review
- Educational, not punitive
- Transparency is important to build trust in process

INTERNAL PEER REVIEW PROCESS

- Cases should be pre-screened
- Defined set of triggers that result in peer review
- Reviewer assigned – ideally same specialty
- Chart review and personal interviews
- Committee presentation and discussion
- Committee votes on final outcome
- Track and trend
- Referral to Medical Executive Committee if applicable
- Provide notified of outcome
- Documentation in Medical Staff file/OPPE report

External Peer Review
When to pursue?

- Need for specialty reviewer not on staff
- Need for non-biased review
- Split decision from peer review committee

EXTERNAL PEER REVIEW PROCESS

- Determine who will cover the cost; Medical Staff vs. Administration
  - Who is requesting the review?
- Contract with organization that provides external peer review
- Develop list of specific criteria for reviewer
  - Education
  - Board certification
  - Demographic region
- Enter into an agreement with an independent reviewer
  - Consult with legal department
- Develop specific questions for reviewer to answer
- Determine how reviewer will access Medical Records
  - Grant access to EMR
  - Upload to file sharing site
- Initiate review
- Close the loop once review is complete

QUESTIONS?

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