NATIONAL ASSOCIATION MEDICAL STAFF SERVICES
NAMSS™
ADVANCING THE DELIVERY OF QUALITY HEALTHCARE

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NAMSS Comparison of Accreditation Standards 2015

About NAMSS

National Association Medical Staff Services (NAMSS) is celebrating more than 30 years of enhancing the professional development of and recognition for professionals in the medical staff and credentialing services field. NAMSS' vision is to advance a healthcare environment that maximizes the patient experience through the delivery of quality services. NAMSS membership includes medical staff and credentialing services professionals from medical group practices, hospitals, managed care organizations, and credentials verifications organizations. For more information, visit NAMSS at *www.namss.org*.

The NAMSS certification programs establish industry standards and serve as a comprehensive measure of knowledge in the field. The Certified Professional in Medical Services Management (CPMSM) and Certified Provider Credentialing Specialist (CPCS) designations identify medical services professionals who have met an established standard of knowledge and understanding in the field of healthcare credentialing, governance, law, accreditation, and regulatory compliance, which help them advance the delivery of quality healthcare.

About Medical Services Professionals

Medical services professionals (MSPs) are individuals charged with the responsibility of ensuring that the hospital and medical staff comply with regulatory and accrediting agencies. MSPs interpret standards and implement change, and are the liaisons among the hospital administration, the medical staff organization, and the governing body. Medical services professionals possess the knowledge and skills required to efficiently manage the medical staff office, coordinate medical staff activities, and provide follow-up required of the medical staff. MSPs are experts at credentialing and assist the medical staff in assuring the hospital that only currently competent applicants are recommended for medical staff membership. MSPs are an invaluable resource to the staff and administration in understanding and applying the standards that the medical staff must meet. Most importantly, the work of medical services professionals helps save patients' lives. MSPs help ensure that doctors meet or exceed the qualifications of a licensed physician, have received the appropriate level of training and experience, are competent, and able to provide services in an appropriate manner.

Introduction

Understanding exactly what a specific accreditation standard or CMS regulation requires can be a difficult task. The *NAMSS Comparison of Accreditation Standards* (revised September 2015) serves as a one-stop resource to help you understand the credentials verification requirements of The Joint Commission, the National Committee for Quality Assurance (NCQA), Healthcare Facilities Accreditation Program (HFAP), Det Norske Veritas (DNV) NIAHO, URAC, the Accreditation Association for Ambulatory Healthcare (AAAHC), and the Medicare Conditions of Participation and Interpretive Guidelines.

The *NAMSS Comparison of Accreditation Standards* is organized by credentialing element and provides you with a "plain-language" interpretation of each accreditation organization's requirements for each element. All interpretations are developed by NAMSS instructors, making this an excellent tool whether you are studying for one of NAMSS' certification exams or simply need a quick review of an accreditation organization's requirements.

Topics include requirements for primary source verification, allied health professionals, designated equivalent sources, professional liability history, peer recommendations, granting of clinical privileges, reappointment, sanctions, temporary privileges, and more.

Accreditation standard and regulation sections include:

- The Joint Commission: Leadership Chapter (LD), Medical Staff Chapter (MS)
- NCQA
- HFAP: Chapter 2 – Allied Health Practitioners, Chapter 3 – Medical Staff
- DNV NIAHO
- AAAHC
- Medicare CoPs: 42 CFR 482

Disclaimer: The language contained in the NAMSS Comparison of Accreditation Standards *is for educational use only. It contains NAMSS interpretations of standards and is not intended to be a replacement for the standards themselves. NAMSS encourages users to refer to this grid in conjunction with the CMS Conditions of Participation and the standards language provided by each accreditation organization.*

Revised September 2015

NAMSS Comparison of Accreditation Standards

The verification requirements listed are considered minimum standards each organization must meet in order to achieve accreditation. Accreditors periodically differ as to what is considered an acceptable source or verification document. The requirements listed are those in effect at the time of publication. Please refer to Web sites of the individual organizations for changes in standards effective after this date of this publication. Please note: In addition to the standards included herein, there are standards that apply individual states which are not covered in this document.

Aspect	THE JOINT COMMISSION 7/1/15 CAMH	NCQA 2015 Health Plan Accreditation and 2013 CVO with updates	HFAP HOSPITAL 2015	DNV-GL NIAHO ACUTE CARE 07/2014 REVISION 11	URAC HEALTH PLAN ACCREDITATION GUIDE, VERSION 7.2 4/2014	AAAHC 2015ACCREDITATION HANDBOOK FOR AHC	MEDICARE HOSPITAL COPS AND INTERP. GUIDELINES - REV. 141, 07-10-15
Ability to Perform Clinical Privileges Requested (Health Status)	The applicant's ability to perform privileges requested must be evaluated and this evaluation documented in the credentials file. The applicant must submit a statement that no health problems exist that could affect the exercise of clinical privileges. On initial appointment, this statement should be confirmed by a director of a training program, the chief of services, or the chief of staff at another hospital where the applicant holds privileges, or an MD or DO approved by the medical staff. If there is doubt about an applicant's ability to perform privileges requested, the medical staff can require an evaluation by an external and/or internal source. Health status is evaluated prior to recommending privileges.	There is a current, signed attestation statement from the applicant regarding the reasons for any inability to perform the essential functions of the position, with or without accommodation, and the lack of present illegal drug use.	Information regarding ability to perform privileges requested (health status is considered for each applicant and reapplicant during the review and approval process. For reapplicants, this can come from peers familiar with their practice; peer review activities; or reviews by the credentials committee, department chair, or medical executive committee. References should include a statement regarding the physician's physical and mental health in relation to privileges requested.	Although not specifically addressed in the standards, the Surveyor Guidance section regarding Surgical Services, instructs surveyors to validate the hospital's method for reviewing practitioners' surgical privileges to determine if the process includes require verification of practitioner training, experience, health status, and performance. Surgical privileges shall correspond with the established competencies of each practitioner.	Application includes disclosure of any physical, mental, or substance abuse problems that could, without reasonable accommodation, impede the practitioner's ability to provide care according to accepted standards of professional performance or pose a threat to the health or safety of patients.	The organization requires and reviews pertinent information concerning the applicant's current physical, mental health, or chemical dependency problems that would interfere with the ability to provide high-quality patient care or services.	Although not specifically addressed in the Regulations, The Interpretative Guidelines for §482.51(a)(4) regarding Surgical Services, instruct surveyors as follows: "Review the hospital's method for reviewing the surgical privileges of practitioners. This method should require a written assessment of the practitioner's training, experience, health status, and performance."
Allied Health Professionals/ Non-Physician Practitioners	The Joint Commission does not use the term "allied health professionals." Rather, it refers to LIPs and Non-LIPs. The Joint Commission defines a licensed independent practitioner as "any individual	Non-physician practitioners who have an independent relationship with the organization and provide care under the organization's medical benefits must be	HFAP standards do not refer to "allied health professionals". Rather, they use the term "non-physician practitioners". Standards regarding non-	The governing body shall determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff. The medical	All practitioners who are participating providers and who provide covered health care services to consumers and those who appear in the organization's provider	If allowed by the organization, the board must provide a process for the initial appointment, reappointment, assignment or curtailment of privileges and practice	Interpretive Guidelines §482.12(a)(1) and §482.22(a) The governing body must determine, in accordance with State law, which

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Allied Health Professionals/ Non-Physician Practitioners (continued)	permitted by law and by the organization to provide care, treatment, and services, without direction or supervision." ***For staff other than PAs and APRNs:*** Human Resources Standards require that, before providing care, treatment or services, the qualifications and competence of a non-employee individual, brought into the hospital by an LIP are assessed by the hospital and are determined to be commensurate with the qualifications and competence required if the individual were to be employed by the hospital to perform the same or similar services. The organization reviews the qualifications, performance, and competence of each non-employee individual brought into the organization by a licensed independent practitioner to provide care, treatment, or services at the same frequency as individuals employed by the organization. ***For PAs and APRNs:*** All LIP PAs and APRNs who are providing a medical level of	credentialed.	physician practitioners are a direct quote of CMS 42 CFR 482.22(a) and §482.12. The following additional comments are included: • The governing body must ensure that any privileges granted to non-physician practitioners are in accordance with State law, regulations, and scope of practice. • Medical Staff Rules delineate the "qualification" process for non-physician first assistants. • The Credentials Committee (function) is responsible for credentialing the medical staff as well as non-physician practitioners who provide a medical level of care, as applicable.	staff must include MDs and DOs. If allowed by State law, including scope-of-practice laws, other categories of non-physician practitioners may be appointed to the medical staff as determined by the Governing body. In accordance with State law, the medical staff may include non-physician practitioners such as PAs, CRNAs, advance practice registered nurses, midwives, psychologists, or other professionals approved by the medical staff and governing body and eligible for appointment. 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 patient care is provided by or in accordance with the orders of a practitioner who meets the medical staff criteria and	directory are credentialed. The organization verifies the qualifications of all AHPs that may provide clinical services to consumers through a written agreement with the organization.	for AHPs (based on State law and evidence of education, training, experience and competency). 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.	categories of practitioners are eligible for appointment to the medical staff. Furthermore, the governing body has the authority, in accordance with State law, to grant medical staff privileges and membership to non-physician practitioners. The corresponding regulation at 42 CFR 482.22(a) allows hospitals and their medical staffs to take advantage of the expertise and skills of all types of practitioners who practice at the hospital when making decisions concerning medical staff privileges and membership. Granting medical staff privileges and membership to non-physician practitioners is an option available to the governing body; it is not a requirement. For non-physician practitioners granted privileges only, the hospital's governing body and its medical staff must

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Allied Health Professionals/ Non-Physician Practitioners (continued)	care (making medical diagnosis and treatment decisions) are credentialed and privileged through the medical staff process. PAs and APRNs who are not providing a medical level of care can be credentialed, privileged, and reprivileged through the medical staff process or an equivalent process that has been approved by the governing body. An equivalent process at a minimum: • Evaluates the applicant's credentials; • Evaluates the applicant's current competence; • Includes peer recommendations; and • Involves communication with and input from individuals and committees, including the MEC, in order to make an informed decision regarding the applicant's request for privileges.			procedures for the privileges granted, who has been granted privileges in accordance with those criteria by the governing body, and who is working within the scope of those granted privileges.			exercise oversight, such as through credentialing and competency review, of those non-physician practitioners to whom it grants privileges, just as it would for those practitioners appointed to its medical staff. Practitioners are described in Section 1842(b)(18)(C) of the Act as any of the following: • Physician assistant (as defined in Section 1861(aa)(5) of the Act); Nurse practitioner (as defined in Section 1861(aa)(5) of the Act); • Clinical nurse specialist (as defined in Section 1861(aa)(5) of the Act); • Certified registered nurse anesthetist (as defined in Section 1861(bb)(2) of the Act); • Certified nurse-midwife (as defined in Section 1861(gg)(2) of the Act); • Clinical social worker (as defined in Section

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Allied Health Professionals/ /Non-Physician Practitioners (continued)							1861(hh)(1) of the Act; • Clinical psychologist (as defined in 42 CFR 410.71 for purposes of Section 1861(ii) of the Act); • Anesthesiologist's Assistant (as defined at §410.69); or • Registered dietician or nutrition professional. Other types of licensed healthcare professionals have a more limited scope of practice and usually are not eligible for hospital medical staff privileges, unless their permitted scope of practice in their State makes them more comparable to the above listed types of non-physician practitioners. Some examples of types of such licensed healthcare professionals who might be eligible for medical staff privileges, depending on State law and medical staff bylaws, rules and regulations include, but are not limited to: • Physical Therapist (as defined at §410.60 and

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Allied Health Professionals/ Non-Physician Practitioners (continued)							§484.4); • Occupational Therapist (as defined at §410.59 and §484.4); and • Speech Language Therapist (as defined at §410.62 and §484.4). Furthermore, some States have established a scope of practice for certain licensed pharmacists who are permitted to provide patient care, services that make them more like the above types of non-physician practitioners, including the monitoring and assessing of patients and ordering medications and laboratory tests. In such States, a hospital may grant medical staff privileges to such pharmacists and/or appoint them as members of the medical staff. There is no standard term for such pharmacists, although they are sometimes referred to as "clinical pharmacists."
Applicant Identity	There must be a mechanism to	Not specifically	Not specifically	Not specifically	Not specifically	Not specifically	Not specifically

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	determine the applicant is the individual identified in the credentialing documents by viewing either a current picture hospital ID card or a valid picture ID issued by a State or Federal agency, such as a driver's license or passport.	addressed.	addressed.	addressed.	addressed.	addressed.	addressed.
Appointment Timeframe Appointment Timeframe (continued)	Not to exceed two years.	Recredential at least every 3 years. NCQA counts the three-year cycle to the month, not to the day. For example, if the organization credentials a practitioner on January 5, 2013, the practitioner must be recredentialed by the end of January 2016.	Standards are a direct quote from §482.22(a)(1) which states that "CMS recommends that an appraisal be conducted at least every 24 months for each practitioner.	As defined by State law, not to exceed three years.	Recredential at least every three years. URAC counts the three-year cycle to the month. For example, if the organization credentials a practitioner on January 5, 2013, the practitioner must be recredentialed by the end of January 2016.	As defined by State law and organizational policy and not to exceed three years.	Interpretive Guidelines §482.22(a)(1) The medical staff must at regular intervals appraise the qualifications of all practitioners appointed to the medical staff/granted medical staff privileges. In the absence of a State law that establishes a timeframe for periodic reappraisal, a hospital's medical staff must conduct a periodic appraisal of each practitioner. CMS recommends that an appraisal be conducted at least every 24 months for each practitioner. Interpretive Guidelines §482.51(a)(4) Surgical privileges should be reviewed and updated at least every two years.

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Attestation Statement Attestation Statement (continued)	Not specifically addressed.	Practitioners complete an application (and reapplication) that includes an inquiry regarding illegal drug use and inability to perform essential functions, history of loss or limitations of licensure or privileges or disciplinary actions, current malpractice coverage, and felony convictions. Attestation must indicate that the applicant personally attests that the application was correct and complete when they applied to the organization. If a copy of an application from an external entity is used, it must include an attestation to the correctness and completeness of the application NCQA does not require the attestation to be received prior to the organization conducting credentialing verifications and queries required for	Responsibilities for credentialed practitioners must include: • participating in Medical Staff functions, committee activity, educational, and QAPI activities; • abiding by bylaws, rules and regulations; and • adhering to ethical practice guidelines. Although not specifically addressed in the standards, the Scoring Procedure for the regulation instructs surveyors to review a select sampling of files to verify practitioners attest to the above-listed responsibilities at appointment and reappointment.	Not specifically addressed.	The application includes a signed and dated statement attesting that the information submitted with the application is complete and accurate to the practitioner's knowledge. Electronic signature is acceptable. Written policies and procedures should establish controls and manage risk for electronic signatures. Examples of acceptable signatures include faxed, digital, electronic, scanned, or photocopied signatures. Time limit is 180 days prior to the credentials committee review.	The application/ reapplication have a formal statement releasing the organization from any liability in connection with credentialing decisions • includes the applicant's attestation to the accuracy and completeness of the application and the information provided. . Written attestation and information includes: • professional liability claims history • information on licensure revocation, suspension, voluntary relinquishment, licensure probationary status, or other licensure conditions or limitations • complaints or adverse action reports filed	Not specifically addressed.

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Attestation Statement (continued)		other elements. Signature can be faxed, scanned, digital, electronic, or photocopied. Use of signature stamp is not allowed unless the practitioner is physically impaired and the disability is documented in the credentials file. If the application's final approval exceeds 365 (305 CVO) days from the date of the signature, the applicant must re-attest to the information being correct and complete. If State regulations require an application not containing an attestation, an addendum to the application for the attestation must be used unless State regulations prohibit.				against the applicant with a local, state, or national professional society or licensure board • refusal or cancellation of professional liability coverage • denial, suspension, limitation, termination, or non-renewal of privileges at any hospital, health plan, medical group, or other health care entity • DEA and state license action • disclosure of any Medicare/Medicaid sanctions • conviction of a criminal offense (other than minor traffic violations • current physical, mental health, or chemical dependency problems that would interfere with an applicant's ability to	

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						provide high-quality patient care and professional services.	
Board Certification Board Certification (continued)	Verification may be obtained directly from the specialty board. ABMS and its certified display agents are considered an equivalent (primary) source. The American Osteopathic Association (AOA) Physician Database can be used for verification of Osteopathic specialty board certification Standards do not address verification of board certification for reappointment/reappraisal. This would be an individual hospital decision dependent upon Bylaws, Rules & Regulations.	Time limit – 180 days MCO and 120 days for CVO. If a practitioner claims to be board certified, the organization must verify it. Verification of board certification meets the requirement for verification of education and residency training. Verification for physicians may be obtained through any of the following: • ABMS, its member boards, and its approved Display Agents. • AOA Official Osteopathic Physician Profile Report. • AOA/AMA Physician Master File; • Confirmation from the specialty board. • Confirmation from the State licensing	The medical staff may not make its recommendation solely on the basis of the presence or absence of board certification, A hospital is not prohibited from requiring Board certification, but this cannot be the only criteria used when considering a physician for medical staff membership. A hospital must also consider the request for clinical privileges, current licensure, training and professional Education, experience, and supporting references of competence. Board certification must be reviewed for each applicant/reapplicant during the review and approval process. Verify with ABMS if physician is certified by a member of board ABMS. If	A hospital may not rely solely on the fact that a physician is Board certified in making a judgment on Medical Staff membership.	Verify board certification, if applicable, or the highest level of education. This is required for initial credentialing only, unless the board certification expires, or if there is no record of the verification in the practitioner's record. If a physician has multiple board certifications, then at a minimum, verify for the specialty under which the practitioner will be listed in the directory. PSV can include the AMA master file, AOA master file, or Special Board of Registry. URAC recognizes those sources that the ABMS has designated as primary equivalents as ones that are primary as well. An organization can rely on the verification	Verify on application, reappointment, expiration, and on an ongoing basis.	§482.12(a)(7) The governing body must ensure that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship or membership in a specialty body or society. In making a judgment on medical staff membership, a hospital may not rely solely on the fact that a MD/DO is, or is not, board-certified. This does not mean that a hospital is prohibited from requiring board certification when considering a MD/DO for medical staff membership, but only that such certification must not be the only factor that the hospital considers. In addition to matters of board certification, a

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Board Certification (continued)		agency if there is confirmation that this agency conducts primary verification of board status. Must document the expiration date of the board certification in the credentialing file. If it is a "lifetime" certification status with no expiration date verify that certification is current and document date of verification. Must verify board certification at recredentialing. If the board does not provide the expiration date, the organization must verify that the board certification is current. Note: verification of board certification is not applicable to nurse practitioners or other health care professionals unless the organization communicates board certification to members. Other health care	certified by an AOA specialty board, verify with AOA Official Osteopathic Physician Profile.		activities of state licensing boards. If this is done, it should be noted in the credentials file. Confirm that the state board does verify a credential before relying on the board. Time limit six months.		hospital must also consider other criteria such as training, character, competence and judgment. After analysis of all of the criteria, if all criteria are met except for board certification, the hospital has the discretion to decide not to select that individual to the medical staff.

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Board Certification (continued)		professionals: Verification must come from the appropriate specialty board, State licensing agency or registry if there is documentation that primary source verification of education and training is performed. If not, the organization must also verify the highest level of education and training. If the organization uses confirmation from a NCQA approved source (such as the State licensing agency or registry), the organization must verify that the source performs PSV, and, at least annually, the organization must obtain written confirmation from the approved source that it performs PSV.					
Complaints	There must be a process for evaluation of the credibility of a complaint, allegation, or concern against a privileged provider. For telemedicine services,	Must continually monitor member complaints for all practitioner sites. There must be a process to monitor and investigate member complaints related to the quality of all	Data collected regarding patient grievances and complaints that are not defined as grievances are reviewed through the QAPI functions.	The hospital must develop and implement a formal grievance procedure, which includes a referral process for quality of care issues to the Utilization Review, Quality	There must be a mechanism for conducting additional review and investigation of credentialing applications in cases where the credentialing process	Risk management process includes an ongoing review of patient complaints and grievances that includes defined response times, as required by law and	§482.13(a)(2) The hospital must establish a process for prompt resolution of patient grievances and must inform each patient

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Complaints (continued)	complaints about the distant site LIP from patients, other LIPs, or staff are reported to the distant site by the originating site.	practitioner office sites and must conduct site visits for complaints related to physical accessibility, physical appearance and adequacy of waiting- and examining-room space if the organization's complaint threshold is met. The organization implements appropriate actions and evaluates the effectiveness of those actions at least every six months, until deficient offices meet the thresholds. The organization must also conduct ongoing monitoring that includes the collection and review of complaints. The organization must have mechanisms in place to investigate practitioner-specific complaints from members upon their receipt. Both the specific complaint and the practitioner's history of issues must be evaluated. There must be evidence of an evaluation of the history of complaints for	At a minimum, the hospital must review and send information to the distant-site telemedicine entity on all adverse events that result from a physician or practitioner's provision of telemedicine services and on all complaints it has received about a telemedicine physician or practitioner.	Management or Peer Review functions, as appropriate.	reveals factors that may affect the quality of care or services delivered to consumers. Parameters or triggers of potential quality of care issues that require further investigation must be included in a policy.	regulation.	whom to contact to file a grievance.

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		all practitioners at least every six months.					
Compliance with Law	A governance standard holds the hospital's governing body responsible to comply with applicable law and regulation. Leaders are responsible to be aware of and comply with local, State, and Federal regulations related to credentialing and privileging of practitioners.	The administrative policies and procedures indicate that organizations providing managed care services must comply with applicable Federal, State, and local laws and regulations, including requirements for licensure. Thus, the organization's leaders are responsible for any regulations relating to credentialing.	Standards require compliance with applicable law and regulations.	Standards require compliance with all applicable Federal, State and local laws.	Standards require compliance with all applicable Federal, State and local laws.	Standards require compliance with all applicable Federal, State and local laws.	Interpretive Guidelines §482.12(a)(3) The governing body must assure that the medical staff has bylaws and that those bylaws comply with State and Federal law and the requirements of CoPs §482.11 Condition of Participation: Compliance with Federal, State and Local Laws Interpretive Guidelines §482.11 The hospital must ensure that all applicable Federal, State and local law requirements are met.
Continuing Medical Education Continuing Medical Education (continued)	LIPs and other practitioners privileged through the medical staff process must participate in CE. Participation must be documented and considered in decisions about reappointment, renewal, or revision of individual clinical privileges. Documentation of attendance can be done in several different ways, including but not limited to:	Not specifically addressed.	Components of practitioner qualifications and demonstrated competencies include maintenance of continuing education. Evidence of continuing educational activities every two years may be requested.	All individuals with delineated clinical privileges participate in continuing education that is at least in part related to their clinical privileges. CME considered in decisions about reappointment or renewal or revision of clinical privileges. Action on an individual's application for appointment	Not specifically addressed.	Not addressed for medical staff members.	Not specifically addressed.

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	• obtaining copies of program certificates • obtaining a copy of the information submitted with a license renewal application when CME's are required by the state • obtaining an attestation statement from the Licensed Independent Practitioner which attests to his/her attendance at CME programs that relate to their area of practice, with the stipulation that proof of attendance and program content will be submitted upon request			/reappointment or initial or subsequent clinical privileges is withheld until the information is available and verified.			
CVOs/Delegation CVOs/Delegation (continued)	The CAMH states that organizations that use information from a CVO should have confidence in the completeness, accuracy, and timeliness of that information and outlines nine principles to evaluate such an agency. Among the necessary aspects are disclosure of data and information available, processes utilized, limitations of information available, identification of primary source information versus information obtained from a secondary source, overview of quality control measures related to data	CVOs are allowed to be used and credentialing policies and procedures include the process used to delegate credentialing and recredentialing, what can be delegated, how the decision to delegate is made. The organization maintains the right to approve/terminate practitioners, and has responsibility for oversight of the delegated agency. There must be a mutually agreed upon document	A professional credentialing organization, such as a CVO can be used to perform PSV, but the process for credentialing by the organization must reflect the requirements as stated in the standards.	Notation under telemedicine states that hospitals may use third-party credentialing verification organizations to compile and verify the credentials of practitioners applying for privileges, but the governing body is still legally responsible for all privileging decisions.	The organization can delegate credentialing. If it does, it must establish and implement criteria and assessment processes prior to the delegation of functions, including a process to conduct a review of the potential contractor's written policies and documented procedures and capacity to perform delegated functions. There must be a written contract.	CVO is allowed. The organization must perform an assessment of the capability and quality of the CVO's work. Accreditation of the CVO by a nationally-recognized organization can meet this requirement.	Not specifically addressed.

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	integrity, security, transmission accuracy, etc.	describing each organizations' responsibilities, the delegated activities, the process for evaluation and outcome if obligations are not fulfilled. There must be, at least, semiannual reporting by the delegated entity to the organization. If the CVO achieves NCQA certification this oversight responsibility is waived. For Medicare deeming, the delegation agreement must include a statement requiring the delegate to adhere to Medicare regulations.					
Criminal Background Checks	Applies to hospital employees: A criminal background check is obtained and documented for the applicant as required by law and regulation or hospital policy.	Not specifically addressed.	The medical staff application must request information regarding any criminal history for 7 to 10 years. The facility conducts criminal background investigation based on information provided in the application or as required by federal and state regulations.	Not specifically addressed. Required if state law requires.	Not specifically addressed.	Background checks not specifically addressed.	Required if State law requires.
Current Competence	The medical staff is responsible for the ongoing evaluation of the competency of privileged	Not specifically addressed. NCQA requires the organization	Criteria for membership and privileges must include current	MS bylaws describe the qualifications to be met by a candidate in order for	Not specifically addressed. The credentialing program	On formal application for initial medical or dental staff privileges, the	§482.12(a)(6) and §482.22(c)(4)

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Current Competence	practitioners. The hospital verifies in writing and from the primary source, whenever feasible, or from a CVO, information concerning the current competence. The provider's ability to perform privileges requested must be evaluated and documented. The organization must review data from professional practice review by other organizations where the applicant currently has privileges, if such data is available. Information from ongoing professional practice evaluation information is used in the decision to maintain, revise, or revoke existing privilege(s) prior to or at the time of renewal. A period of focused professional practice evaluation is implemented for all initially requested privileges. Medical staff defines circumstances requiring monitoring and evaluation of a practitioner's professional performance.	to assess the practitioner's ability to deliver care based on the credentialing information collected and verified prior to making a credentialing decision. The organization develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality.	competence. Evaluation and granting of clinical privileges must be commensurate with the individual's documented training, experience, and current competence. Applicants must provide clinical activity documentation and competency to be used in consideration of privileges requested. This can come from residency or from facilities where the applicant has been practicing. They must also provide procedure logs with outcomes to support privilege requests for procedures not attested to in postgraduate references. Reapplicants provide departmental recommendations. Low volume may require review of procedure logs and competency from other facilities including recent experience and recommendations from QA committee and/or other committees based	the medical staff to recommend that the governing body appoint the candidate. Those qualifications shall include verification of current competence on initial appointment and reappointment. Verification required prior to granting temporary privileges. Surgical privileges correspond with the established competencies of each practitioner. Practitioner specific performance data is evaluated, analyzed and appropriate action taken as necessary when variation is present and/or standard of care has not been met as determined by the medical staff. Performance data collected periodically within the reappointment period or as required as a part of the peer review process. This may include comparative and/or national data if available.	defines the organization's criteria for qualification as a participating provider. The credentialing program includes a statement that credentialing decisions will be based on multiple criteria related to professional competency, quality of care and the appropriateness by which health services are provided.	applicant must provide documentation of current competency in performing the requested procedures. Documentation of current competence is obtained from peers.	The governing body must ensure that the criteria for selection of medical staff are individual character, competence, training, experience, and judgment

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(continued)			upon peer review findings. Ongoing professional practice evaluation (OPPE) information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), and/or to revoke an existing privilege prior to or at the time of renewal. Data is collected on an ongoing basis and summarized at least three (3) times during each two-year appointment cycle. (Effective 1/2015) The organized medical staff defines the circumstances requiring additional, focused monitoring and evaluation of a practitioner's professional performance. (Effective 1/2015)				
Designated Equivalent Sources	Designated equivalent sources may be used to verify certain credentials in lieu of using the primary source. Designated equivalent sources include but are not limited to: • AMA Physician Masterfile for a physician's U.S. or	NCQA does not use the language "designated equivalent sources." See each credentialing element for a listing of NCQA-approved sources. Verification of credentials	• FSMB or Fraud and Abuse Control Information Systems (FACIS) for actions against a physician's medical license • AMA Physician's Profile, AOA Official	Verification of education required on initial appointment. AMA profile and ECFMG accepted. AMA/AOA Profile listed in temporary privileges	URAC does not use the language "designated equivalent sources." Primary source verification may include state licensing board, school/residency/training program, board	AAHC refers to "secondary sources." Secondary source verification is documented verification of a credential through obtaining a verification report from an entity listed below as	Not specifically addressed.

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Designated Equivalent Sources (continued)	Puerto Rican medical school graduation and residency completion. • ABMS for a physician's board certification. • ECFMG for a physician's graduation from a foreign medical school. • AOA Physician Database for a physician's predoctoral education accredited by the AOA Bureau of Professional Education, postdoctoral education approved by the AOA Council on Postdoctoral Training, and Osteopathic Specialty Board Certification. • FSMB for all actions against a physician's medical license. • AAPA profile for PA education and NCCPA certification.	through an agent that contracts with an approved source to provide credentialing information is allowed. Prior to using this method documentation must be obtained from the agent indicating that there is a contractual relationship between it and the approved source.	Osteopathic Physician Profile, for verification of medical education and postgraduate training. • ECFMG for verification of foreign medical education • NPDB query for professional liability actions resulting in final settlements or judgments within the past five years. • If certified by a member of board ABMS, verify board certification with ABMS; if certified by a specialty board of AOA, verify with AOA Official Osteopathic Physician Profile.	standard.	certification via the AMA master file, AOA master file, ECFMG, or Special Board of Registry. NPDB for sanctions from state licensing boards and Medicare/Medicaid. An organization can rely on the verification activities of state licensing boards. If this is done, it should be noted in the credentials file. Confirm that the state board does verify a credential before relying on the board. Time limit six months.	acceptable on the basis of that entity having performed the primary source verification. Resources for verification of credentials listed on the AAAHC Web site are: • American Medical Association Physician Master Profile. • Federation of Chiropractic Licensing Boards. • American Association of Dental Examiners. • Drug Enforcement Agency (DEA.) • Association of American Medical Colleges. • American Association of Colleges of Nursing. • American Academy of Physician Assistants. • American Association of Colleges of Podiatric Medicine. • Accreditation Council for Graduate Medical Education.	

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Designated Equivalent Sources (continued)						• Federation of State Medical Boards. • American Osteopathic Association . • American Association of Nurse Anesthetists. • American Board of Medical Specialties. • American Dental Association (Specialty Boards Recognized by ADA). • American Podiatric Medical Association (Specialty Boards Recognized by the AMPA). • American Osteopathic Information Association. • American Nurses Credentialing Center. • American College of Nurse-Midwives. • Educational Commission for Foreign Medical Graduates. • National Commission on Certification of Physician Assistants.	

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Designated Equivalent Sources (continued)						Information from another health care organization, such as a hospital or group practice that has carried out primary source or acceptable secondary source verification, can be used provided the organization supplies directly, without transmission or involvement by the applicant or other third party, original documents or photocopies of the verification reports it has relied upon. Information received from a CVO is also acceptable as long as it meets the CVO requirements.	
Disaster or Emergency Management Plan Privileges	During disasters, disaster privileges may be granted to volunteer LIPs when the Emergency Operations Plan has been activated in response to a disaster and the hospital is unable to meet immediate patient needs. If the organization's usual credentialing and privileging processes can't be performed	Not specifically addressed.	The Medical Staff Bylaws provide for a Medical Staff chief and/or the CEO to grant emergency privileges to a practitioner to accomplish lifesaving procedures, within the scope of his/her license, during such times that reasonably suggest that a staff member who is a credentialed practitioner	Bylaws must include a process for approving practitioners for care of patients in the event of an emergency or disaster.	Not specifically addressed.	When hospitalization is needed due to emergencies, the organization may have a policy for credentialing and privileging physicians and dentists who have admitting and privileges at a nearby hospital.	Interpretive Guidelines §482.41(a) The hospital must coordinate with Federal, State, and local emergency preparedness and health authorities to identify likely risks for their area (e.g., natural disasters, bioterrorism threats, disruption of

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Disaster or Emergency Management Plan Privileges (continued)	due to the disaster, a modified credentialing and privileging process can be used on a case-by-case basis. Medical staff bylaws must identify the individual(s) responsible for granting disaster privilege. The medical staff must have a documented mechanism for oversight of the professional performance of volunteer practitioners who receive disaster privileges, which can be accomplished through direct observation, mentoring, and/or clinical record review. There must be a mechanism to identify volunteer practitioners functioning under disaster privileges. In order to be considered for disaster privileges as an LIP, volunteers the organization must obtain, at a minimum, present a valid government-issued photo ID from a state or federal agency, such as a driver's license or passport, and at least one of the following: • Current picture hospital ID		with appropriate privileges is not available. Temporary privileges can be used in time of emergency and/or disaster. The hospital has a plan for dealing with clinical volunteers during emergency/disaster. This plan should provide for primary source ID from the volunteer's hospital (A documented phone call is acceptable). The hospital should use volunteers as appropriate within the scope of their license/certification.				utilities such as water, sewer, electrical communications, fuel; nuclear accidents, industrial accidents, and other likely mass casualties, etc.) and to develop appropriate responses that will assure the safety and well-being of patients [this includes]… Qualifications and training needed by personnel, including healthcare staff, security staff, and maintenance staff, to implement and carry out emergency procedures

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Disaster or Emergency Management Plan Privileges (continued)	card with professional designation; • Current license to practice; • PSV of license; • Identification indicating the volunteer is a member of a Disaster Medical Assistance Team, the Medical Reserve Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or another recognized federal, state, or municipal entity; • Identification indicating that the individual has been granted authority to render patient care, treatment, and services during disaster by a federal, state, or municipal entity; or • Identification by a current hospital employee or medical staff member with personal knowledge of ability of the volunteer to act independently during a disaster. Primary source verification of						

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Disaster or Emergency Management Plan Privileges (continued)	license must begin as soon as the immediate situation is under control or within 72 hours from the time the volunteer LIP begins working at the hospital, whichever occurs first. The organization must make a decision within 72 hours related to the continuation of the disaster privileges initially granted based on information obtained in the medical staff's oversight of the volunteer. It is not necessary to obtain PSV of licensure if the volunteer LIP has not provided care, treatment, or services under the disaster privileges.						
Drug Enforcement Agency Certificate (DEA) or State Controlled Dangerous Substances Certificate	Before recommending privileges, the medical staff evaluates challenges to any licensure or registration.	DEA or Controlled Dangerous Substances (CDS) certificate verified in each state where the practitioner provides care to its members through one of the following: • A copy of the DEA or	Application includes actions against DEA certificate or state CDS certificate.	MS bylaws describe the qualifications to be met by a candidate in order for the medical staff to recommend that the governing body appoint the candidate. Those qualifications shall	Evidence of current DEA certificate or state controlled dangerous substance certificate is submitted with application, if applicable. The organization may	Evaluated on initial appointment, reappointment, expiration and monitored continually.	Not specifically addressed.

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Drug Enforcement Agency Certificate (DEA) or State Controlled Dangerous Substances Certificate (continued)		CDS certificate. • Documented visual inspection of the original certificate. • Confirmation with the DEA or CDS Agency. • Confirmation with National Technical Information Service (NTIS) database. • AMA Physician Masterfile (DEA only) • Confirmation from the State pharmaceutical licensing agency, where applicable. • (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File. If the practitioner does not prescribe medications requiring DEA or CDS certificate, there must be a documented process to require an explanation as to why the practitioner does not prescribe medications. There must		include current DEA number on initial appointment and reappointment, if required. Medical staff criteria for consideration of automatic suspension includes when the practitioner's DEA certificate has been revoked, suspended or on probation for any reason.	either collect a copy of the certificate or the certificate number. Verification time limit is six months.		

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		be arrangements for the practitioner's patients who need prescriptions for medications requiring DEA or CDS certification. The 180/120-day time limitation does not apply to this element providing the DEA/CDS is current at the time of action/transmittal.					
Education Education (continued)	On recommendations of the medical staff and approval by the governing body, the hospital establishes criteria that determine a practitioner's ability to provide patient care, treatment, and services within the scope of the privileges requested including verification of relevant education. Verification for MDs and DO can come from: • The school • American Medical Association (AMA) Physician Masterfile (as of 1996) for all U.S. or Puerto Rican medical school graduation. • Education Commission for Foreign Medical Graduates (ECFMG) for foreign	*The organization need only verify the highest level of credentials attained.* For example, if a physician is board certified, verification of board certification meets this element because specialty boards verify education and training. Residency is considered the highest level of training, not fellowship. Any of the following can be used to verify education and training: • The primary source • The state licensing agency or specialty	PSV is required and includes AMA Physicians Profile, AOA Official Osteopathic Physician Profile, and Educational Commission for Foreign Medial Graduates (ECFMG). Documentation regarding training and education must be sufficient to support requested privileges.	MS bylaws describe the qualifications to be met by a candidate in order for the medical staff to recommend that the governing body appoint the candidate. Those qualifications shall include verification of education on initial appointment. AMA Profile and ECFMG acceptable.	History of education and professional training included on application. PSV can include state licensing board, school/residency/training program. An organization can rely on the verification activities of State licensing boards. If this is done, it should be noted in the credentials file. Confirm that the State board does verify a credential before relying on the board. Verification not required if the practitioner is board certified. Time limit six months.	Education is verified with primary source on initial appointment.	§482.12(a)(6) and §482.22(c)(4) The governing body must ensure that the criteria for selection of medical staff are individual character, competence, training, experience, and judgment

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Education (continued)	medical school. • The American Osteopathic Association (AOA) Physician Masterfile. • The AAPA profile can be used for Verification of PA education and NCCPA certification.	board, or registry* • Sealed transcripts may be accepted if the organization shows evidence that it inspected the contents of the envelope and confirmed that practitioner completed (graduated from) the appropriate training program. Other acceptable sources for physicians (MDs are: • • AMA Physician Masterfile. • AOA Official Osteopathic Physician Profile or AOA Physician Master File. • Educational Commission for Foreign Medical Graduates for international medical graduates after 1986.					

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		• • FCVS for closed residency programs. *If the organization uses confirmation from a NCQA approved source, (such as the State licensing agency or registry) the organization must verify that the source performs PSV, and, at least annually, the organization must obtain written confirmation from the approved source that it performs primary source verification. NCQA does not require the organization to obtain written confirmation from the licensing board if there is a state statute that requires the licensing board to obtain verification of education and training directly from the institution. Verification time limit: Prior to the credentialing decision.					
Felony Convictions	Not specifically addressed.	The application must include a statement regarding felony convictions.	The application requests information regarding any criminal history and a criminal background	Not specifically addressed.	Not specifically addressed.	The applicant must provide information regarding criminal convictions other than	Not specifically addressed.

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Felony Convictions (continued)			investigation is conducted based on information provided in the application or as required by Federal and State regulations.			minor traffic violations.	
Licensure/Licensure Sanctions	Licensure is verified with the primary source at the time of appointment and initial granting of clinical privileges; at reappointment, renewal, or revision of clinical privileges, and on expiration. Before recommending privileges, the medical staff evaluates challenges to or voluntary/involuntary relinquishment of any license or registration. FSMB is recognized as a designated equivalent source for information regarding licensure actions.	Time limit – 180 days MCO and 120 days for CVO. • Confirm that the practitioner holds a valid, current license, in effect at the time of the Credentialing Committee's decision. • Verify license only in the states where the practitioner provides care for organization members. • Verification directly with state licensing agency. If the organization uses the Internet to verify licensure, the Web site must be from the appropriate State licensing agency. NPDB and Continuous Query can be used to verify sanctions. The organization must	Verification of current license(s), licensure sanction(s), state(s) of current practice or intended practice, and all previous licenses held. For telemedicine, verify licensure in state where patient is located and where the telemedicine provider is located. Must meet applicable State or local laws. Sanctions or disciplinary actions taken by healthcare facilities, specialty boards, Federal or State agencies, malpractice carriers must be reviewed for each applicant/reapplicant during the review and approval process. For sanctions, PSV from State licensing agency(ies) and NPDB.	MS bylaws describe the qualifications to be met by a candidate in order for the medical staff to recommend that the governing body appoint the candidate. Those qualifications shall include verification of licensure on initial appointment and reappointment. Sanctions not specifically addressed.	Current license(s) and history of licensure in all jurisdictions included on application. There must be verification of licensure or certification as minimally required to engage in clinical practice. License or certificate verifications include the expiration date, the date verified, and whether there are any sanctions on the license. Tapes purchased from the state boards can be used. The license must be current and valid when presented to the credentialing committee. The practitioner should identify sanctions from state licensing boards. History of sanctions should include a minimum of five years licensure	Verified and documented on initial appointment, reappointment, expiration, and continually monitored thereafter. Information on licensure revocation, suspension, voluntary relinquishment, probationary status, or other conditions/limitations, and complaints or adverse action reports from licensure board reviewed on initial and reappointment.	§482.12(a)(6) and §482.22(c)(4) The governing body must ensure that the criteria for selection of medical staff are individual character, competence, training, experience, and judgment Sanctions not specifically addressed.

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Licensure/ Licensure Sanctions (continued)		verify the most recent 5 year period available for sanctions or limitations on licensure in each state where the practitioner provides care for its members using one of the following: **Physicians** • Appropriate State agencies. • FSMB. • NPDB (Continuous Query). **Chiropractors** • Federation of Chiropractic Licensing Boards' Chiropractic Information Network-Board Action Databank (CIN-BAD). • State Board of Chiropractic Examiners. **Oral Surgeons** • NPDB (Continuous Query). • State Board of Dental Examiners. **Podiatrists** • Federation of Podiatric Medical	Application includes information regarding previously successful and/or currently pending (if available) challenges to any license, and/or voluntary or involuntary relinquishment of his/her license. Can use results from search of Federation of State Medical Boards (FSMB) Disciplinary Action Databank or Fraud and Abuse Control Information Systems (FACIS). If telemedicine is utilized, the process for validation of licensure must be enforced (scoring procedure).		history. PSV may include Education Commission for Foreign Graduates, or Special Board of Registry. Can use NPDB or the primary source for sanctions. Time limit six months.		

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Licensure/ Licensure Sanctions (continued)		Boards. • State Board of Podiatric Examiners. • NPDB (Continuous Query). **Non-physician behavioral healthcare professionals** • Appropriate State agency. • State licensure or certification board. • NPDB (Continuous Query) Organizations are responsible for the ongoing monitoring of sanctions or limitations on licensure between recredentialing cycles. On initial credentialing, practitioners attest to any loss of license since initial licensure was granted. On recredentialing, practitioners attest to loss of licensure since the last credentialing cycle.					
Malpractice Coverage/ Professional	Not addressed. However, if the medical staff bylaws/ rules/regulations require	The application form must include specific questions regarding the dates and	Must have evidence of professional liability insurance including	Medical staff criteria for consideration of automatic suspension includes when	Proof of liability insurance included on application.	Documentation of professional liability insurance present if	Not specifically addressed.

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Liability Coverage Malpractice Coverage/ Professional Liability Coverage (continued)	malpractice coverage, it is expected that the organization have a method to verify such coverage.	amount of a practitioner's current malpractice insurance or the organization may obtain a copy of the insurance face sheet from the malpractice carrier. For practitioners with federal tort coverage, the practitioner file can include a copy of the federal tort letter or an attestation from the practitioner of federal tort coverage. For reapplication, the application or an addendum to the application must include dates and amount of current malpractice coverage, or obtain copy of the insurance fact sheet with information.	current certificates showing amount insurance.	the practitioner has failed to maintain the minimum specified amount of professional liability insurance as required in the medical staff bylaws.	A cover sheet or attestation from the insurance company is sufficient to prove attainment of liability coverage. The cover sheet must include the name of the practitioner, expiration date and the liability covered. If the cover sheet does not include the name of the practitioner, a photocopy of those covered under the plan must be submitted to the requester on a sheet that includes the insurer's letterhead. The cover sheet must be current and valid when presented to the credentialing committee. For practitioners who will be starting at a later date, a letter from the insurance company with the future start date and description of the liability coverage is acceptable.	required by the organization. Monitored on appointment, reappointment, expiration and on an ongoing basis). Information regarding refusal or cancellation of professional liability coverage provided by the applicant reviewed at initial and reappointment.	
Malpractice/ Professional Liability History	Before recommending privileges, the medical staff evaluates any evidence of an	Time limit – 180 days MCO and 120 days for CVO. Applies to initial	At least the past five year history of professional liability actions resulting	Review of involvement in any professional liability action at initial and	Professional liability claims history included on application.	Professional liability claims history provided and evaluated on initial	Not specifically addressed.

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	unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant.	and recredentialing. Verify the history of professional liability claims resulting in settlements or judgments paid by or on behalf of the practitioner and must obtain written confirmation of past five years history of malpractice settlements from the malpractice carrier or NPDB (continuous query can be used). Not required for practitioners covered under a hospital insurance policy during a residency or fellowship.	in final settlements or judgments must be evaluated. Malpractice litigation history (final judgments and settlements) is received from insurance carrier or NPDB.	reappointment.	Professional liability claims history is defined as cases that are settled or have resulted in an adverse judgment against the provider. Time limit six months.	and reappointment.	
Medicare/ Medicaid Sanctions	Not specifically addressed.	Time limit – 180 days MCO and 120 days for CVO. This applies to both initial and recredentialing. Verification of past Medicare/Medicaid sanctions may be done through a query of one of the following: • Federal Employees Health Benefits Plan (FEHB) Program department record, published by the Office of Personnel Management, Office	Sanctions or disciplinary actions taken by healthcare facilities, specialty boards, federal or state agencies, malpractice carriers must be reviewed for each applicant/reapplicant during the review and approval process. The application requests information regarding disciplinary actions taken or investigations pending by Medicare/Medicaid.	Bylaws provide a mechanism for immediate and automatic suspension of privileges due to the termination or revocation of Medicare or Medicaid status. OIG Medicare/Medicaid Exclusions verified at initial, reappointment, and when granting temporary privileges.	Required to be reported on application. Can verify with issuing organization or NPDB. Time limit six months.	Information concerning Medicare/Medicaid sanctions disclosed and evaluated on initial and reappointment.	Not specifically addressed.

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		of the Inspector General • FSMB • *List of Excluded Individuals and Entities* (maintained by OIG), available over the Internet • Medicare Exclusions Database • NPDB • AMA Physician Masterfile State Medicaid agency or intermediary and Medicare intermediary. Organizations are responsible for the ongoing monitoring of Medicare/ Medicaid sanctions between recredentialing cycles.					
National Practitioner Data Bank	Query of NPDB is required when clinical privileges are initially granted, on renewal of privileges, and when new privileges are requested (including temporary privileges).	The NPDB is an acceptable source for sanctions or limitations on licensure, Medicare/ Medicaid sanctions, and malpractice history.	Query of NPDB is required on initial and reappointment. The application requests information on actions listed in the NPDB.	Query of NPDB is required on initial and reappointment and grating of temporary privileges.	Not required, but can use to verify licensure sanctions and Medicare/Medicaid sanctions.	NPDB query required at initial and reappointment. Continuous Query acceptable.	Interpretive Guidelines §482.22(a)(1) …whenever a practitioner's privileges are limited, revoked, or in any way constrained, the hospital must, in accordance with State and/or Federal laws or regulations, report those constraints to the appropriate State and

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							Federal authorities, registries, and/or data bases, such as the National Practitioner Data Bank.
Peer Recommendation Peer Recommendation (continued)	The medical staff must use peer recommendations in its consideration of recommendations for appointment and initial granting of privileges and in consideration of termination from the medical staff or revision/revocation of clinical privileges. Peer recommendations should include evaluation of the applicant's medical/clinical knowledge, technical and clinical skills, clinical judgment, communication skills, interpersonal skills, and professionalism. Peer recommendations are obtained from a practitioner in the same professional discipline as the applicant with personal knowledge of the applicant. Peer recommendations can include written documentation reflecting informed opinions on each applicant's scope and	There is no specific requirement for peer recommendations. The organization must designate a Credentialing Committee that uses a peer-review process to make recommendations regarding credentialing decisions. The intent of this standard is that the organization obtains meaningful advice and expertise from participating practitioners in making credentialing decisions.	For initial appointment, recommendations/ references must be obtained from at least one peer with the same professional credential as the applicant that includes a statement regarding the physician's physical and mental health in relation to privileges requested. If there is not one with the same professional credential available, then a practitioner in the same practice area who can speak to the applicant/re-applicant's professional competence and ethical standards can provide the reference. For physicians seeking reapplication, individual letters of recommendation are not required. For re-applicants, routine review functions; such as clinical peer review, medical	MS bylaws describe the qualifications to be met by a candidate in order for the medical staff to recommend that the governing body appoint the candidate. Those qualifications shall include two peer recommendations on initial appointment.	There is no specific requirement for peer recommendations other than that a peer group makes the final credentialing determination.	Required for initial and reappointment.	Not specifically addressed.

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Peer Recommendation (continued)	level of performance, or a written peer evaluation of practitioner-specific data collected from various sources for validating current competence. The following are appropriate sources for peer recommendations: • An organization performance improvement committee, the majority of whose members are the applicant's peers. • Reference letter(s), written documentation, or documented phone conversation(s) about the applicant from a peer (practitioner in the same professional discipline as the applicant) who has personal knowledge of the applicant. • A department or major clinical service chairperson who is a peer. • The MEC. When renewing privileges, if there are insufficient practitioner-specific data available, the medical staff uses and evaluates peer recommendations.		records review, credentials function, and Medical Executive Committee is sufficient. Clinical competence review must be a component of recredentialing.				

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Practitioners Credentialed and Privileged through the Medical Staff (See also AHP section) Practitioners Credentialed and Privileged (See also AHP section) (continued)	All individuals who are permitted by law and the hospital to provide patient care independently in the hospital — whether or not medical staff members (Licensed Independent Practitioners) are required to be credentialed and privileged under the Medical Staff standards. This includes LIPs who are hospital employees. For hospitals that use Joint Commission accreditation for deemed status purposes: In accordance with state law, including scope of practice laws, the medical staff may also include other categories of physicians listed at 482.12(c)(1) as well as nonphysician practitioners determined to be eligible for appointment by the governing body.	Note: NCQA standards address credentialing, not privileging. Practitioners within the scope of credentialing: • Practitioners licensed, certified or registered by the state to practice independently (without direction or supervision). • Practitioners who have an independent relationship with the organization. • Practitioners who provide care under the organization's medical benefits. This would include the following: • Individual/group practices • Facilities • Rental networks • Telemedicine Credentialing policies and procedures include Medical practitioners (medical doctors.	Standards regarding medical staff composition are a direct quote of CMS 42 CFR 482.22(a) and §482.12(a)(1). The following additional comments are included: The governing body must ensure that any privileges granted to non-physician practitioners are in accordance with State law, regulations, and scope of practice. •	The organization shall have an organized medical staff that is composed of fully licensed doctors of medicine or osteopathy. In accordance with State law, the medical staff may also include other practitioners included in the definition in Section 1861(r) of the Social Security Act of a physician: • Doctor of medicine or osteopathy; • Doctor of dental surgery or of dental medicine; • Doctor of podiatric medicine; • Doctor of optometry; and • Chiropractor The governing body shall determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff. In accordance with State law, the medical staff may include non-physician practitioners such as PAs,	All practitioners listed in the directory and are providing covered healthcare services to consumers are credentialed. Examples include • MDs/DOs • Chiropractors • Non-Physicians including nurse practitioners, physician assistants, nutritionists, etc. • Alternative Medicine Providers – massage therapists, acupuncturists, etc. • Mental Health Providers – psychologists, certified addiction specialists, etc. • Acute in-patient facilities such as hospitals • Free-standing surgical centers This includes individual practitioners providing clinical services in group practice settings and free-standing clinics even if the individual	At a minimum, physicians and dentists are credentialed and privileged. Board determines which other qualified professionals (AHPs) it wishes to allow on staff.	Interpretive Guidelines §482.12(a)(1) and §482.22(a) The hospital's governing body has the responsibility, consistent with State law, including scope-of-practice laws, to determine which types/categories of physicians and, if it so chooses, non-physician practitioners or other licensed healthcare professionals (collectively referred to in this guidance as "practitioners") may be privileged to provide care to hospital patients. All practitioners who require privileges in order to furnish care to hospital patients must be evaluated under the hospital's medical staff privileging system before the hospital's governing body may grant them privileges. All practitioners granted medical staff privileges must function under the bylaws, regulations and rules of the hospital's

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Practitioners Credentialed and Privileged (See also AHP section) (continued)		oral surgeons. chiropractors. osteopaths. podiatrists. nurse practitioners. other medical practitioners) and Behavioral healthcare practitioners (psychiatrists and other physicians, addiction medicine specialists).		CRNAs, APRNs, midwives, psychologists, or other professionals approved by the medical staff and governing body and eligible for appointment.	practitioners are not listed in the organization's provider directory or do not contract directly with the network organization. Physicians who are employees of a facility as hospitalists and who are not listed in the provider directory are not included.		medical staff. The privileges granted to an individual practitioner must be consistent with State scope-of-practice laws. **Physicians:** The medical staff must at a minimum be composed of doctors of medicine or doctors of osteopathy. In addition, the medical staff may include other types of practitioners included in the definition in Section 1861(r) of the Social Security Act of a "physician:" • Doctor of dental surgery or of dental medicine; • Doctor of podiatric medicine; • Doctor of optometry; and a • Chiropractor. In all cases, the practitioner included in the definition of a physician must be legally authorized to practice within the State where the hospital is located and providing services within

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Practitioners Credentialed and Privileged (See also AHP section) (continued)							their authorized scope of practice. In addition, in certain instances the Social Security Act and regulations attach further limitations as to the type of hospital services for which a practitioner may be considered to be a "physician." See §482.12(c)(1) for more detail on these limitations. The governing body has the flexibility to determine, consistent with State law, whether practitioners included in the definition of a physician, other than doctors of medicine or osteopathy, are eligible for appointment to the medical staff. For physician practitioners granted privileges only, , the hospital's governing body and its medical staff must exercise oversight, such as through credentialing and competency review, of those other physician practitioners to whom it grants privileges, just as it would for those

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Practitioners Credentialed and Privileged (See also AHP section) (continued)							practitioners appointed to its medical staff. **Non-physician practitioners** Furthermore, the governing body has the authority, in accordance with State law, to grant medical staff privileges and membership to non-physician practitioners. The corresponding regulation at 42 CFR 482.22(a) allows hospitals and their medical staffs to take advantage of the expertise and skills of all types of practitioners who practice at the hospital when making decisions concerning medical staff privileges and membership. Granting medical staff privileges and membership to non-physician practitioners is an option available to the governing body; it is not a requirement. For non-physician practitioners granted privileges only, the hospital's governing body

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Practitioners Credentialed and Privileged (See also AHP section) (continued)							and its medical staff must exercise oversight, such as through credentialing and competency review, of those non-physician practitioners to whom it grants privileges, just as it would for those practitioners appointed to its medical staff. Practitioners are described in Section 1842(b)(18)(C) of the Act as any of the following: • Physician assistant (as defined in Section 1861(aa)(5) of the Act); Nurse practitioner (as defined in Section 1861(aa)(5) of the Act); • Clinical nurse specialist (as defined in Section 1861(aa)(5) of the Act); • Certified registered nurse anesthetist (as defined in Section 1861(bb)(2) of the Act); • Certified nurse-midwife (as defined in Section 1861(gg)(2) of the Act);

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Practitioners Credentialed and Privileged (See also AHP							• Clinical social worker (as defined in Section 1861(hh)(1) of the Act; • Clinical psychologist (as defined in 42 CFR 410.71 for purposes of Section 1861(ii) of the Act); • Anesthesiologist's Assistant (as defined at §410.69); or • Registered dietician or nutrition professional. Other types of licensed healthcare professionals have a more limited scope of practice and usually are not eligible for hospital medical staff privileges, unless their permitted scope of practice in their State makes them more comparable to the above listed types of non-physician practitioners. Some examples of types of such licensed healthcare professionals who might be eligible for medical staff privileges, depending on State law and medical staff bylaws, rules and regulations

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section) (continued)							include, but are not limited to: • Physical Therapist (as defined at §410.60 and §484.4); • Occupational Therapist (as defined at §410.59 and §484.4); and • Speech Language Therapist (as defined at §410.62 and §484.4). Furthermore, some States have established a scope of practice for certain licensed pharmacists who are permitted to provide patient care, services that make them more like the above types of non-physician practitioners, including the monitoring and assessing of patients and ordering medications and laboratory tests. In such States, a hospital may grant medical staff privileges to such pharmacists and/or appoint them as members of the medical staff. There is no standard term for such pharmacists,

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							although they are sometimes referred to as "clinical pharmacists."
Privileges Privileges (continued)	The hospital must have a clearly documented procedure for the processing of requests for initial granting, renewal, or revision of privileges. This process must be approved by the medical staff. The privilege delineation system is tailored to the hospital (hospital specific) and must take into account the hospital's technical and staff capability of supporting the procedures. Standards require all LIPs (defined as individuals who are permitted by law and the hospital to provide care, treatment, or services without direction or supervision) to be privileged through the medical staff process. The organization can only grant privileges when the facility has the necessary resources to support the privilege or will have the resources available in a specified time period. An objective, evidenced-based process must be used to grant	Verification of clinical privileges is not required.	Standards are a direct quote from §482.12(a), §482.12(a)(1) through §482.12(a)(6) and§482.51(a)(4).	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 patient care is provided by or in accordance with the orders of a practitioner who meets the medical staff criteria and procedures for the privileges granted, who has been granted privileges in accordance with those criteria by the governing body, and who is working within the scope of those granted privileges. The medical staff bylaws shall describe the organization of the medical staff and include a statement of the duties and privileges of each category of medical staff to ensure that acceptable standards are met for	Application includes hospital affiliations or privileges, if applicable.	Privileging is a three-phase process that includes, determination of the clinical procedures and treatments to be offered to patients, determination of the qualifications (training and experience) required to obtain each privilege, establishment of a process for evaluating the applicant's qualifications using appropriate criteria, and approving or modifying privileges in a non-arbitrary manner. Privileges for specific procedures are granted for a specified period of time based on the applicant's qualifications within the services provided by the organization. The health care professional must be legally and professionally qualified for the privileges granted. Mechanisms must be in	Interpretive Guidelines §482.22(c)(4) The medical staff bylaws must describe the qualifications to be met by a candidate for medical staff membership/ privileges in order for the medical staff to recommend the candidate be approved by the governing body. The bylaws must describe the privileging process to be used in the hospital. The process articulated in the medical staff bylaws must include criteria for determining the privileges that may be granted to individual practitioners and a procedure for applying the criteria to individual practitioners that considers: • Individual character; • Individual competence; • Individual training; • Individual experience; and • Individual judgment.

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Privileges (continued)	or deny privileges and when renewing existing privileges. The hospital must establish the criteria used to determine a practitioner's ability to provide patient care, treatment, and services within the scope of the requested privileges. These criteria must be based on the medical staff's recommendations and must be approved by the governing body. Criteria must include consistent evaluation of • PSV for current licensure or certification. • PSV of relevant training. • Evidence of physical ability to perform the requested privilege. • If available, data from professional practice review from other organization where the applicant currently has privileges. • Recommendations from peers/faculty. • On renewal, review of the applicant's performance within the hospital.			providing patient care for all diagnostic, medical, surgical and rehabilitative services. Medical staff bylaws include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to those individuals that request privileges. Appointment or reappointments to the medical staff and the granting, renewal, or revision of clinical privileges shall be made for a period defined by State law or if permitted by State law, not to exceed three years. All individuals permitted by the organization and by law to provide patient care services independently in the organization shall have delineated clinical privileges. There shall be a provision in the medical staff		place to notify licensing and/or disciplinary bodies or other authorities when privileges are suspended or terminated. The organization has its own independent process of credentialing and privileging that includes review and approval by the governing body. Appointment or privileges may not be approved solely on the basis that another organization, such as a hospital, took such action, although this information can be used in consideration of the application. The organization ensures that its facility provides a safe environment, including granting privileges for each specific device. For Medicare deeming, privileges must be periodically appraised and the scope of privileges periodically reviewed and amended as appropriate.	§482.22(c)(6) - [The bylaws must:] Include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges. For distant-site physicians and practitioners requesting privileges to furnish telemedicine services under an agreement with the hospital, the criteria for determining privileges and the procedure for applying the criteria are also subject to the requirements in §482.12(a)(8) and (a)(9), and §482.22(a)(3) and (a)(4). All patient care is provided by or in accordance with the orders of a practitioner who meets the medical staff criteria and procedures for the privileges granted, who has been granted privileges in accordance with those criteria by the

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Privileges (continued)				bylaws for a mechanism to ensure that all individuals with clinical privileges provide services only within the scope of privileges granted. If available and/or required by the medical staff to hold or maintain clinical privileges, privileging includes 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. All practitioners performing surgery have surgical privileges established by the organization's department of surgery and medical staff and approved by the governing body. Surgical privileges shall correspond with the established competencies of each practitioner. The medical staff has a provision to authorize		The ASC must assure that all physicians performing surgery have privileges at a local Medicare participating hospital or a nonparticipating hospital under Title 42 CFR Section 482.2 [416.41(b)(2)]. In a solo medical or dental practice, the provider's credentials file and granting of privileges must be reviewed by an outside physician or dentist (as applicable) at least every three years (or as required by state law or organization) with documentation provided to the organization.	governing body, and who is working within the scope of those granted privileges. Privileges are granted by the hospital's governing body to individual practitioners based on the medical staff's review of that individual practitioner's qualifications and the medical staff's recommendations for that individual practitioner to the governing body. However, in the case of telemedicine physicians and practitioners providing telemedicine services under an agreement, the governing body has the option of having the medical staff rely upon the credentialing and privileging decisions of the distant-site hospital or telemedicine entity with which the hospital has entered into an agreement. When the governing body has exercised this option, the medical staff's bylaws must include a provision

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Privileges (continued)				qualified licensed practitioners to order outpatient services within their scope of services/\.			allowing the medical staff to rely upon the credentialing and privileging decisions of a distant-site hospital or telemedicine entity when that distant-site hospital or entity is required under the terms of its agreement with the hospital to employ a credentialing and privileging process that conforms to the provisions of §482.12(a)(8) and (a)(9), and §482.22(a)(3) and (a)(4). §482.12(a)(2)Only the hospital's governing body has the authority to grant a practitioner privileges to provide care in the hospital. 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) (see below) and who has been granted medical staff privileges, or under the care of a practitioner who is directly under the

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Privileges (continued)							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. §482.22(c)(2) The bylaws must include a statement of the duties and privileges of each category of medical staff (e.g., active, courtesy, etc.) The medical staff bylaws must state the duties and scope of medical staff privileges each category of practitioner may be granted. Specific privileges for each category must clearly and completely list the specific privileges or limitations for that category of practitioner. The specific privileges must reflect activities that the majority of

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							practitioners in that category can perform competently and that the hospital can support. The individual practitioner's ability to perform each task/activity/privilege must be individually assessed. See also "Practitioners Credentialed and Privileged" section above.
Residency/ Fellowship Training	At the time of appointment to membership and initial granting of privileges, verification of relevant training or experience must be obtained from the primary source(s) or a designated equivalent source. In addition to contacting the primary source (the training program) TJC allows use of the following designated equivalent sources: • The American Medical Association (AMA) Physician Masterfile. • (AOA) Physician Database for postdoctoral education approved by the AOA Council on Postdoctoral Training	*The organization must only verify the highest level of credentials attained.* For example, if a physician is board certified, verification of board certification meets this element because specialty boards verify education and training. (Verification of fellowship does not meet this requirement). NCQA only recognizes residency programs that have been accredited by the ACGME, College of Family Physicians of Canada, or the Royal College of Physicians and	PSV includes direct contact with program, AMA Physicians Profile (MDs), AOA Official Osteopathic Physician Profile (DOs). Need documentation regarding training and education sufficient to support requested privileges.	Medical staff bylaws include criteria for determining the privileges to be granted to individual practitioners, including specific training. AMA Master Profile is acceptable.	History of education and professional training included on application. PSV can include State licensing board, school/residency/training program. An organization can rely on the verification activities of State licensing boards. If this is done, it should be noted in the credentials file. Confirm that the State board does verify a credential before relying on the board. Verify highest level of	Relevant education and training verified with primary source on initial appointment. Experience reviewed for continuity and relevance with documentation of any interruptions.	§482.12(a)(6) and §482.22(c)(4) The governing body must ensure that the criteria for selection of medical staff are individual character, competence, training, experience, and judgment

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Residency/ Fellowship Training (continued)		Surgeons of Canada. Any of the following can be used to verify training: • The primary source • The state licensing agency or specialty board, or registry* • Sealed transcripts may be accepted if the organization shows evidence that it inspected the contents of the envelope and confirmed that practitioner completed (graduated from) the appropriate training program. Other acceptable sources for physicians (MDs, DOs) are: • AMA Physician Masterfile. • American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File.			education/training. (No need to verify education/training if board certification is verified.) Time limit six months.		

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		• FCVS for closed residency programs. *If the organization uses confirmation from a NCQA approved source, the organization must verify that the source performs PSV, and, at least annually, the organization must obtain written confirmation from the approved source that it performs primary source verification.					
Site Visit	Not required.	The organization implements appropriate interventions by conducting site visits of offices about which it has received member complaints when established thresholds are exceeded. (See Complaints section.)	Not required.	Not required.	Not required.	Not required.	Not specifically addressed.
Telemedicine	Telemedicine standards for originating site only: LIPs providing patient care services via telemedicine are subject to the credentialing and privileging processes of the originating site. Three options are available for	Not specifically addressed	HFAP standards are a direct quotation of the CMS regulations §482.12(a). (See CMS section.)	NIAHO standards are a direct quotation of the CMS regulations (see CMS section) with the following addition: Medical Staff defines applies criteria for determining the privileges to be granted to individual	Not specifically addressed.	Not specifically addressed. If provided by contract, the governing body maintains responsibility.	§482.12(a) Standard: Medical Staff. [The governing body must:] (8) Ensure that, when telemedicine services are furnished to the hospital's patients through an agreement with a distant-site hospital, the agreement is written and

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Telemedicine (continued)	credentialing at the originating site: A. The originating site can fully privilege and credential the practitioner according to MS standards. B. The practitioner may be privileged at the originating site using credentialing information from the distant site if the distant site is a Joint Commission-accredited organization. The distant-site practitioner must have a license issued or recognized by the state in which the patient is receiving telemedicine services C. The originating site can use credentialing and privileging decision from the distant site to make a final determination if all the following requirements are met: • The distant site is a TJC-accredited hospital or ambulatory care organization. If an ambulatory care organization, the hospital must verify that the distant site made its decision using the process described in Standards MS.06.01.03			practitioners and a procedure for applying the criteria to individuals requesting privileges. For distant-site physicians and practitioners requesting privileges to furnish telemedicine services under an agreement with the hospital, the criteria for determining privileges and the procedure for applying the criteria are also subject to these requirements. The distant site entity or hospital must meet NIAHO credentialing standards in addition to Medicare CoPs.			that it specifies that it is the responsibility of the governing body of the distant-site hospital to meet the requirements in paragraphs (a)(1) through (a)(7) of this section with regard to the distant –site hospital's physicians and practitioners providing telemedicine services. The governing body of the hospital whose patients are receiving the telemedicine services may, in accordance with §482.22(a)(3) of this part, grant privileges based on its medical staff recommendations that rely on information provided by the distant-site hospital. (9) Ensure that when telemedicine services are furnished to the hospital's patients through an agreement with a distant-site telemedicine entity, the written agreement specifies that the distant-site telemedicine entity is a contractor of services to the hospital and as such, in accordance with

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Telemedicine (continued)	through MS.06.01.07 (excluding EP 2 from MS.06.01.03). • The practitioner is privileged at the distant site for those services to be provided at the originating site • For hospitals that use TJC for deemed status: The originating site receives a current list of the LIP's privileges from the distant site. • The originating site provides the distant site with internal performance review information that can be utilized to assess the practitioner's quality of care, treatment, and services for use in PI and privileging including adverse outcomes related to sentinel events resulting from the telemedicine services provided; and complaints from patients, LIPs, or staff. For hospitals that use Joint Commission accreditation for deemed status purposes; the originating site makes certain that all distant-site telemedicine providers' credentialing and						§482.12(e), furnishes the contracted services in a manner that permits the hospital to comply with all applicable conditions of participation for the contracted services, including, but not limited to, the requirements in paragraphs (a)(1) through (a)(7) of this section with regard to the distant-site telemedicine entity's physicians and practitioners providing telemedicine services. The governing body of the hospital whose patients are receiving the telemedicine services may, in accordance with §482.22(a)(4) of this part, grant privileges to physicians and practitioners employed by the distant-site telemedicine entity based on such hospital's medical staff recommendations; such staff recommendations may rely on information provided by the distant-site telemedicine entity. §482.22(a)(3) - When

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Telemedicine (continued)	privileging processes meet, at a minimum, the Medicare CoPs for credentialing medical staff. If the hospital does NOT use TJC accreditation for deeming purposes, the following apply: If the hospital contracts with another accredited organization for patient care, treatment, and services that are to be provided off site, it has two options: 1. The organization can verify that all LIPs have appropriate privileges by obtaining a copy of the privileges list and /or 2. Include a requirement in the contract that the contracted organization will ensure that all services provided by contracted LIPs will be within the scope of their privileges. For hospitals that use Joint Commission accreditation for deemed status purposes: The originating site must have a written agreement with the distant site that specifies the following: • The distant site is a						telemedicine services are furnished to the hospital's patients through an agreement with a distant-site hospital, the governing body of the hospital whose patients are receiving the telemedicine services may choose, in lieu of the requirements in paragraphs (a)(1) and (a)(2) of this section, to have its medical staff rely upon the credentialing and privileging decisions made by the distant-site hospital when making recommendations on privileges for the individual distant-site physicians and practitioners providing such services, if the hospital's governing body ensures, through its written agreement with the distant-site hospital, that all of the following provisions are met: (i) The distant-site hospital providing the telemedicine services is a Medicare-participating hospital. (ii) The individual distant-site

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Telemedicine (continued)	contractor of services to the hospital. • The distant site furnishes services in a manner that permits the originating site to be in compliance with the Medicare CoPs • The originating site makes certain through the written agreement that all distant-site telemedicine providers' credentialing and privileging processes meet the Medicare CoPs related to credentialing. If the originating site chooses to use the credentialing and privileging decision of the distant-site telemedicine provider, then the following requirements apply: • The governing body of the distant site is responsible for having a process that is consistent with the credentialing and privileging requirements in the "Medical Staff" (MS) chapter (Standards MS.06.01.01 through						physician or practitioner is privileged at the distant-site hospital providing the telemedicine services, which provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital. (iii) The individual distant-site physician or practitioner holds a license issued or recognized by the State in which the hospital whose patients are receiving the telemedicine services is located. (iv) With respect to a distant-site physician or practitioner, who holds current privileges at the hospital whose patients are receiving the telemedicine services, the hospital has evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and sends the distant-site hospital such performance information for use in the periodic appraisal of the distant-site physician or practitioner. At a

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Telemedicine (continued)	MS.06.01.13). • The governing body of the originating site grants privileges to a distant site LIP based on the originating site's medical staff recommendations, which rely on information provided by the distant site. In addition, the medical staffs at both the originating and distant sites must recommend the clinical services to be provided by licensed independent practitioners through a telemedicine link at their respective sites and clinical services offered must be consistent with commonly accepted quality standards.						minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the hospital's patients and all complaints the hospital has received about the distant-site physician or practitioner. §482.22(a)(4) When telemedicine services are furnished to the hospital's patients through an agreement with a distant-site telemedicine entity, the governing body of the hospital whose patients are receiving the telemedicine services may choose, in lieu of the requirements in paragraphs (a)(1) and (a)(2) of this section, to have its medical staff rely upon the credentialing and privileging decisions made by the distant- site telemedicine entity when making recommendations on privileges for the individual distant-site

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Telemedicine (continued)							physicians and practitioners providing such services, if the hospital's governing body ensures, through its written agreement with the distant-site telemedicine entity, that the distant-site telemedicine entity furnishes services that, in accordance with §482.12(e), permit the hospital to comply with all applicable conditions of participation for the contracted services. The hospital's governing body must also ensure, through its written agreement with the distant-site telemedicine entity, that all of the following provisions are met: (i) The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at §482.12(a)(1) through (a)(7) and §482.22(a)(1) through (a)(2). (ii) The individual distant-site physician or practitioner is privileged

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Telemedicine (continued)							at the distant-site telemedicine entity providing the telemedicine services, which provides the hospital with a current list of the distant-site physician's or practitioner's privileges at the distant-site telemedicine entity. (iii) The individual distant-site physician or practitioner holds a license issued or recognized by the State in which the hospital whose patients are receiving such telemedicine services is located. (iv) With respect to a distant-site physician or practitioner, who holds current privileges at the hospital whose patients are receiving the telemedicine services, the hospital has evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and sends the distant-site telemedicine entity such performance information for use in the periodic

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							appraisal of the distant-site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the hospital's patients, and all complaints the hospital has received about the distant-site physician or practitioner. [The bylaws must:] §482.22(c)(6) - Include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges. For distant-site physicians and practitioners requesting privileges to furnish telemedicine services under an agreement with the hospital, the criteria for determining privileges and the procedure for applying the criteria are also subject to the requirements in

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							§482.12(a)(8) and (a)(9), and §482.22(a)(3) and (a)(4). When telemedicine (including teleradiology) is used and the practitioner and patient are located in different states, the practitioner providing the patient care service must be licensed and/or meet the other applicable standards that are required by State or local laws in both the state where the practitioner is located and the state where the patient is located.
Temporary Privileges/Provisional Credentialing	The CEO or his or her designee, upon recommendation of the president of the medical staff or designee, may grant temporary privileges, in two cases: 1. Urgent patient care need for a limited period of time as defined by the organization, after current licensure and competence are verified 2. New applicants awaiting medical staff review and	NCQA standards do not reference privileges, but they do have a process for Provisional Credentialing. An organization may conduct a one-time provisional credentialing of practitioners who are applying to the organization for the first time, prior to initial credentialing. The organization may not hold practitioners in	Bylaws provide for the granting of temporary privileges: • During review and consideration of application, after completion of process for files waiting to be presented to MEC and governing body. • For care of specific patient(s). • For locum tenens. • For times of	Criteria for granting temporary privileges: • Verification of education (AMA/AOA Profile). • Demonstration of current competence. • Verification of State professional licenses. • Receipt of professional references (including current competence); and,	The organization can grant "provisional" participation status for a limited time when justified by continuity or quality of care issues on approval of the senior clinical staff person.	Not specifically addressed.	Not specifically addressed.

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Temporary Privileges/Provisional Credentialing (continued)	approval after verification of the following: • Current licensure. • Relevant training or experience. • Current competence. • Ability to perform the privileges requested. • Any criteria required by the organized medical staff bylaws. • NPDB query. • Complete application. In addition, in order to be granted temporary privileges, there must be no current or previously successful challenges to licensure or registration, involuntary termination of medical staff membership at another organization, or involuntary limitation, reduction, denial, or loss of clinical privileges.	provisional status for more than 60 days. Provisional credentialing files must be valid and verified within the specified time frames. They must contain evidence of the approval of the medical director or equally qualified practitioner (must be a physician), if the file meets the organization's definition of a "clean file"; or they must be presented to the Credentialing Committee for review and consideration for participation into the network. The following criteria must be met prior to the decision to grant provisional credentialing: • PSV of license. • Written confirmation is of the past five years of malpractice settlements obtained from the malpractice carrier or NPDB query. • The application must	emergency or disaster. Privileges are granted upon recommendation of the chief/chair of a department or service and the CEO of the facility or his or her designee who is acting on behalf of the governing body. They must be time-limited and taken only when sufficient evidence exists that the granting of temporary privileges is prudent. Granting of temporary privileges occurs only after verification of licensure, DEA, insurance, and at least one recent reference from a previous facility, chief, or department chair. Limits to the number of specific patients who may be cared for must be identified. Locum tenens privileges may be granted for specific periods of time. These periods to not have to be sequential.	• Receipt of database profiles from AMA, AOA, NPDB, OIG Medicare/Medicaid Exclusions. The CEO or designee may grant when dictated by urgent patient care need or when an application is complete without any negative or adverse information before action is taken by the medical staff or governing body. Must be on recommendation of a member of the medical executive committee, the president of the medical staff, or the medical director (as defined by the medical staff). Cannot exceed 120 days. Locum tenens or similar temporary staff may be used for a period not to exceed six (6) months. The medical staff bylaws define, and medical staff completes, the required the process for approval of physicians and other practitioners providing such services.			

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		be current and include attestation.					
Work History Work History (continued)	There is no specific requirement for verification of work history. The standards require, at the time of appointment to membership and initial granting of privileges, verification of relevant training or experience must be obtained from the primary source(s), whenever feasible. The hospital requirements are to evaluate voluntary or involuntary termination of medical staff membership and voluntary or involuntary limitation, reduction, or loss of clinical privileges. According to an FAQ on TJC's website: "Simply verifying affiliations would not meet these requirements. If you ask the questions of the applicant, usually in the application, and the applicant's answers do not conflict with the information obtained when you query the NPDB, then there is no need to contact the other facilities or licensing/registration bodies. You would only need to contact them if the information conflicts."	Verification time limit: 365 calendar days NCQA does not require PSV of work history. A minimum of five years of relevant work history must be obtained through the practitioner's application or curriculum vitae. Documentation of review of work history through can be done thorough documentation on the application or CV that includes the signature or initials of staff who reviewed work history and the date of review. Gaps exceeding six months must be reviewed and clarified either verbally or in writing. Verbal clarification in the practitioner's credentialing file. CV or application must include the beginning and ending month and year for each position in the practitioner's employment experience. If a practitioner has had continuous employment for five years or more,	Verification of healthcare employment and work history is required. Verification should include a confirmation of the applicant's appointment and privilege history, and any pending investigations of disciplinary actions, voluntary resignations, or relinquishments of membership/clinical privileges/contracts. Applicants must provide clinical activity documentation and competency to be used in consideration of privileges requested. This can come from residency or from facilities where the applicant has been practicing. They must also provide procedure logs with outcomes to support privilege requests for procedures not attested to in postgraduate references.	Although work history is not specifically addressed, the medical staff bylaws must include criteria for determining the privileges to be granted to individual practitioners, including experience.	Not specifically addressed, but application must include hospital affiliations and privileges and history of loss or limitation of privileges or disciplinary activity.	On initial appointment, experience is reviewed for continuity and relevance with documentation of any interruptions. CMS requires Medicare Certified ASCs to have either a written transfer agreement with a hospital or to ensure that all physicians performing surgery in the ASC have admitting privileges at a nearby hospital.	Not specifically addressed.

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		then there is no gap and no need to provide the month and year, if the year meets the intent. On initial credentialing, practitioners attest to loss or limitation of privileges or disciplinary actions since their initial licensure. On recredentialing, practitioners attest to loss or limitation of privileges or disciplinary actions since the last credentialing cycle.					