HCCA | *Mark Eddy, CPA* | *April 18, 2013*

Credentialing and Privileging Process Review Guidelines

WHY ***DO*** WE DO THIS?

Centers for Medicare & Medicaid Services (CMS)

Requirements for Hospital Medical Staff Privileging

The hospital's Governing Body must ensure that all practitioners who provide a medical level of care and/or conduct surgical procedures in the hospital are individually evaluated by its Medical Staff and that those practitioners possess current qualifications and demonstrated competencies for the privileges granted. State Survey Agency (SA) surveyors are to determine whether the hospital's privileging process and its implementation of that process comply with the hospital Conditions of Participation (CoPs).

Joint Commission Standard

- All licensed independent practitioners who provide care, treatment, and services possess a current license, certification, or registration as required by law and regulation.
- The hospital collects information regarding each practitioner's current license status, training, experience, competence, and ability to perform the requested privilege. MS.06.01.03

WHY ***SHOULD*** WE DO THIS?

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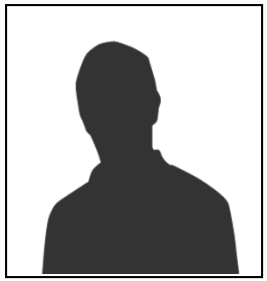
A Doctor's Tale Shows Weaknesses In Medical Vetting

Despite Erratic Education, Trail of Suits, Dr. King Got Job at HCA Hospital Then He Started Operating

By PAUL DAVIES | Staff Reporter



HURRICANE, W.Va. -- John Anderson King joined the staff of Putnam General Hospital here in November 2002. In seven months, the orthopedic surgeon performed about 500 operations, mainly on patients' spines, arms and legs.

During a routine review of the doctor's work, the hospital became concerned about some of his surgeries. In May 2003, Putnam, which is owned by the giant hospital chain HCA, Inc. suspended his privileges, pending an internal investigation.

Edgar M. Dawson, a Los Angeles surgeon brought in for a peer review, called Dr. King a "snake-oil salesman" who was "not competent to practice medicine," according to a lawsuit Dr. King later filed against the surgeon in federal court in Los Angeles. In August 2003, before the hospital completed its inquiry, Dr. King resigned and turned in his West Virginia medical license.

Putnam and Dr. King's patients are still reeling from the surgeon's brief tenure. More than 100 malpractice suits have been filed against Dr. King and the hospital, according to state-court records in Putnam County, W.Va. Dozens of patients blame chronic back pain on allegedly unnecessary surgeries, court records show. None of the suits has been resolved.

One 90-year-old man died in 2003 from complications allegedly related to a back operation Dr. King is accused of recommending, despite the patient's age. A 38-year-old woman had her leg amputated in 2003 after an allegedly unsuccessful foot operation. State-court suits filed on behalf of the woman and the man's estate are pending. The suits accuse Dr. King of malpractice and the hospital of negligence in recruiting and employing him.

Many of the suits allege that Putnam overlooked warning signs, such as Dr. King's stop-and-start education, discrepancies in his résumé, and his involvement in past lawsuits, some of which he

How Do We Audit This?

Overview

All privileged and non-privileged practitioners providing services at Company-affiliated facilities must comply with all Federal, State, and professional requirements applicable to their respective discipline and license. All practitioners who provide and/or order tests or services which require licensure, certification or other credentials must have a valid license, certificate, credentials, and are not ineligible persons or persons who are excluded from participation in an applicable state healthcare program. All privileged and non-privileged practitioners performing and or ordering tests/services must have appropriate licensure and exclusion status checks at defined time frames. Each company-affiliated facility must ensure that Federal Health Programs are not billed for any services, tests, or treatments rendered based upon the order or direction of a physician or other practitioner who is an ineligible person.

Overview

Privileged practitioners who are granted privileges by an appropriate authority of a Company-affiliated facility, such as the Board of Trustees, must provide those services within the **defined limits** based on an individual practitioner's license, education, training, experience, competence, health status, and judgment. The hospital must have processes in place to enforce the parameters of privileging and legally required credentials.

CREDENTIALING
SERVICE CENTERS

Administrative Procedures

- Schedule a planning meeting with appropriate management.
- Audit team members should be evaluated to ensure their objectivity and independence is not impaired (in fact or appearance). Items to consider include:
  - Family relationships
  - Specific operations for which they were previously responsible
  - Previous accounting assistance assignments

  If an impairment exists, consult with the applicable Vice President to consider reassigning the auditor or implementing compensating controls (i.e., additional scrutiny, etc.).

  Document the objectivity evaluation, conclusions, and any compensating controls.
- Obtain and review the Prior Audit Report.

Administrative Procedures

- Ensure the Timetracker template is imported in Teammate. Complete the following:
  - Check daily to ensure teammates are completing the Timetracker appropriately.
  - If you note that someone has not been completing the Timetracker at all, remind them to complete it.
    - If someone is entering a lot of "other" time without explaining it, please remind them to make the appropriate notes at the bottom of the spreadsheet.
- Pull samples for review:
  1. Timeliness of Initial Credentialing Instances
  2. QA review of re-credentialing instances
  3. Letter Series Review:
     1. Sent not Received
     2. Request for Credentialing (RFC)/Recurring Request for Credentialing (RRFC) Incomplete
     3. Accelerated Request for Credentialing (RFC)/Recurring Request for Credentialing (RRFC) Incomplete
     4. Letter Verification to Received
  4. Credentialing Complete Communication
  5. Medical Staff Office (MSO) Due Date Changes

Administrative Procedures

- Schedule the Entrance Conference to include the Shared Service Center (SSC) CEO, Credentialing AVP, and Directors. This is a time for Credentialing Processing Center (CPC) personnel and audit team members to meet each other and to help identify with whom each will be working during the field week. Document details of the Entrance Conference on the Entrance Conference Documentation template.
- Prepare the Executive Summary with front page statistics and cc list (Draft and Final).
- Copy all background issues into the Background Issues template. If information is obtained through conversations with CEO and/or AVP, document their names and titles in the standard paragraph and nothing else needs to be done. If information in the issues is obtained through another source (i.e. reports), reference this information to the source. If the issue states differences between policies, be sure to reference the policy and highlight policy differences.

Administrative Procedures

- Schedule the exit conference.
- Document exit conference details on the respective Exit Conference Documentation template.

Credentialing Procedures

- Through discussions with CPC personnel, gain an understanding of the HCO (HCA Credentialing Online) process.
- Perform an analytical (high-level) review of Initial Credentialing Turn Around Time Reports and document observations.

  Select a sample of 25 initial credentialing instances that were not completed within the standard. Test the timeliness of the credentialing process based on CPC policies and standards.
- Using Business Objects or Cactus queries, ensure providers who went through credentialing for temporary privileges were also credentialed for full appointment or were properly statused as inactive after 120 days. Perform follow-up with CPC or sample noted providers.

Credentialing Procedures

- Select a random sample of re-credentialing instances. Perform a QA review of the instances ensuring the following:
  - The information on the Credentialing Verification Instance (CVI) was updated correctly (i.e., the correct information was keyed to the CVI).
  - The appropriate verification source/method was documented for all items requiring verification .
  - The accurate verification date was documented for all items requiring verification.
  - Cactus documents were attached to the correct provider.
  - Cactus documents were attached to the correct Cactus form per the Image Matrix.
- Select a sample of 25 completed credentialing instances. Ensure communication between the CPC and MSO that occurs after the instance is placed in a final stats ('MSO File Review' or 'Credentialing Complete, MSO Red Flag') is in compliance with policy.

Credentialing Procedures

- Select a sample of 25 credentialing instances that have changes in the MSO due dates. Review the instances in Cactus to ensure policy compliance with the following:
  - MSO due dates were extended in 15 day increments.
  - Documentation exists as to why the due date was changed.
  - The reason for the MSO due date change is listed as an acceptable reason per policy.

Letter Series Procedures

- Through discussions with CPC personnel, gain an understanding of the DMO (Document Management Outbound) process.
- Select a sample of 25 credentialing instances (ensure both initial and re-credentialing instances are included) in which it took longer than 60 days to receive the completed RFC/RRFC application back from the provider. Ensure CPC personnel performed timely and appropriate follow-up and escalation per.
- Select a sample of 25 credentialing instances (ensure both initial and re-credentialing instances are included) in which the RFC/RRFC application was received incomplete. Ensure CPC personnel performed timely and appropriate follow-up and escalation per policy.

Letter Series Procedures

- Select a sample of 15 accelerated initial credentialing instances in which the RFC application was received incomplete. Ensure CPC personnel performed timely and appropriate follow-up and escalation per policy.
- Select a sample of 25 credentialing instances (ensure both initial and re-credentialing instances are included) in which it took longer than 60 days to complete the verification process. Ensure CPC personnel performed timely and appropriate follow-up and escalation per policy.

Expirables Procedures

- Through discussion with CPC personnel, determine the process in place for performing dynamic credentialing as it concerns expired credentials (i.e., State Licenses & Certifications, Life Supports, Insurance, and Board Certifications).
- Obtain the scripts utilized by the CPC to monitor for the following expired credentials: Malpractice Insurance, Board Certifications, State Licenses & Certifications, and Life Support Certifications. Perform a high-level review of the scripts for reasonableness. If the scripts appear reasonable, run them to obtain a list of providers with expired credentials. Perform follow-up with CPC personnel to determine why the providers credentials are noted as expired and what is being done to remediate the procedures.

Expirables – Corporate Review

- Through discussion with Parallon credentialing personnel, determine the process in place for reconciling provider data as it concerns expired credentials (i.e., state licenses and Drug Enforcement Agency (DEA) certifications).
- Obtain the most recently completed monthly expirable reports (state license reports for the states that were completed that month and the DEA report) from Parallon credentialing personnel. Select a sample of providers for review to determine whether CPC personnel are performing follow-up appropriately and timely.

CREDENTIALING
FACILITIES

Administrative Procedures

- Using risk based criteria, run a Business Objects (BO) report to obtain a practitioner activity report (i.e., controlled drugs orders, procedures performed, number of patients admitted), and use the Cactus report to determine if the provider was credentialed by the CPC and approved by the facility. Use the BO report to determine high and/or low volume activity to determine the practitioner sample selection. Once the practitioners are determined, request/pull an exception report regarding medical, state, and Drug Enforcement Agency (DEA) Licenses for the practitioners being reviewed.
- Select a sample of hospitals from the risk based report. Select privileged practitioners from each hospital. Review the hospital's "Meditech Provider Dictionary" (or other report if used by the facility), and select non-privileged/out-of-state practioners from each hospital. (**Note**: Facilities may choose to establish a "MOX" cabinet to track providers who are ineligible, non-licensed, or otherwise sanctioned, if available). Document the methodology utilized for the sample selection.

Administrative Procedures

- Notify the facility, division, group, Credentialing Processing Center (CPC), and Clinical Services Group (CSG) management as stated within the Internal Audit Protocol of the upcoming audit and request that the facility complete and return the Internal Control Questioner (ICQ). Based on the ICQ responses, determine areas that may need further follow-up with the facility/center.

Licensure Review Process

1. Review the most recent 12 month period for any privileged practitioner's state, medical, and Drug Enforcement Agency (DEA) licensure exceptions. Privileged practitioners must have licensure checks at appointment, reappointment, and prior to expiration.
2. Review the privileged practitioner's DEA licensure verification of current DEA numbers on appointment, reappointment, and before expiration. DEA verifications need to be conducted for controlled schedules. Check the Nurse Practitioners and Physician Assistant state authorization link for ordering narcotics. **Refer to the DEA matrix for definition**.
   http://www.deadiversion.usdoj.gov/drugreg/practioners/mlpbystate.pdf
   Determine if the provider has a DEA exception/limitation.
3. Determine if the DEA license is in the state where the provider is practicing or from a different state.
4. Determine if tests, services, or treatments were provided by order of an ineligible practitioner by running a Business Objects (or other) report.

Licensure Review Process

5. Determine if each Company-affiliated facility has a process to search (every 30 days) the HHS/OIG List of Excluded Individuals/Entities (the "OIG Sanction Report") and the General Service Administration's exclusion records in the System for Award Management (SAM) (the "GSA List") list to ensure that no affiliate, physician, privileged practitioner, or independent/dependent practitioner or contractor is an Ineligible Person, or any individual or entity currently excluded is on a state exclusion list. (**Note**: The data on the OIG Sanction Report and GSA List has been combined by Compliance Concepts, Inc. (CCI) and is available at the CCI website at: http://app.sanctioncheck.com and The OIG Sanction Report and the GSA List are available in searchable formats on the Internet at: http://exclusions.oig.hhs.gov). Non-privileged practitioners must have state, medical licensure and OIG/GSA exclusion checks conducted within 3 days of ordering services and/or prior to billing of the tests/services performed.
6. Determine payments made per the Remittance Advices (RA) for any services, tests, or treatments ordered or performed by an unlicensed or ineligible practitioner.
7. Discuss all identified issues with facility administration, Medical Staff Office (MSO), Division Vice President of Quality (DVPQ), CPC and CSG personnel as applicable.

PRIVILEGING

Review Process

1. Review Cactus to ensure clinical privileges are setting specific and well defined on appointment/reappointment with appropriate Board approval dates. Setting specific means that providers have not been granted any privileges that are not performed at the facility, for example an OB/GYN physician can only be granted GYN privileges if the facility does not provide obstetric services. The hospital is equipped appropriately allowing the provider to safely perform the service. Well defined means that the privileges have been described in sufficient detail to allow a determination of what is, or is not within the scope of privileges granted. If core/bundles privileges are used, the core/bundles privileges must be clearly and accurately defined to reflect specific activities/procedures, and/or privileges that are outside the core, for example, core privileges for "general surgery" does not sufficiently defined the service.
2. Review Cactus to ensure it includes evidence of ability to perform requested privileges (peer-competence, performance data, and evaluation reviews) at appointment and reappointment. If this is not included in Cactus, request the information from the MSO. This is applicable when the practitioner requests an increase in privileges.

Review Process

3. Review Cactus to ensure it includes documentation of liability actions, terminations at another hospital, license challenges, medical training/education, and statements to determine/reflect if there are any health or impairment issues that would prevent the applicant from safely performing the privileges requested. Additionally, the peers who provide a reference should be asked the same about the applicant to validate the responses.
4. Review to ensure that when new privileges are added (i.e., a physician goes through DaVinci training), the following occurs: 1) the privilege delineation is updated; 2) there is evidence of board approval; and 3) documentation of notification of approval to the physician. Discussions with the facility may include asking the facility if they have new technology like DaVinci, review the board minutes for the approved added technology, and look in the credentials files for the three listed elements as noted above. Documented evidence of approval of temporary privileges will come from the CEO and Chief of Staff, or a medical staff designee such as the department chairman.

Review Process

5. Ensure there is evidence that the practitioner does not practice outside the scope of his/her privileges, and tests/services are not performed per the order of an ineligible provides. Pull a Business Objects (or other) report of procedures performed by the provider. Obtain a report for services provided within the past 12 month period or within a defined period of time based on privileging grants and/or exclusions. Note payments per the RA for services performed outside the provider's scope of practice.
6. Review identified issues with the facility administration, MSO, DVPQs, CSG, and CPC personnel as applicable.
7. Develop "Draft" report, conduct exit conference, and follow protocol as defined in the audit program.
8. An action plan will be developed by the facility for any noted issues.

QUESTIONS?