

Connecticut Valley Hospital Credentialing and Privileging Manual

SUGGESTED CHANGES 2019



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Credentialing and Privileging Manual

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Section 1: Introduction to Credentialing and Privileging



Introduction to Credentialing and Privileging of the Medical Staff at CVH

Per the Medical Staff By-Laws, Section 7, the Credentialing and Privileging (C&P) Committee shall consist of the appointed chair, the Chief of Staff and Chief of Professional Services as ex-officio members, at least one psychiatrist from each division and one physician from Ambulatory Care Services. The Executive Committee may appoint additional physician or non-physician members if it deems this necessary.

1. The Credentialing and Privileging Committee shall:

- A. Gather, authenticate and evaluate all necessary information to assure that an applicant possesses the necessary qualifications for an appointment and reappointment to the Medical Staff and is appropriately trained, maintaining competence and capable of carrying out any privileges granted to him/her.
- B. Revise any forms and procedures in this process to comply with any changes in Medical Staff By-Laws, information sources, and State Statutes.
- C. Provide the Executive committee of the Medical Staff with recommendations regarding the credentials and privileges of any application, or Medical staff member, applying for or reapplying for Medical Staff membership, privileges, or delineated clinical activities.
- D. Have available for the Executive Committee's inspection any and all documentation to support its recommendations.
- E. Maintain a permanent record of its proceedings, findings and recommendations.
- F. Present a quarterly report summarizing its activities to the Executive Committee of the Medical staff.

2. Meetings: The Committee will meet at least quarterly and more frequently, if necessary.

The Credentialing and Privileging meeting currently meets on the second (2nd) Thursday of each month at 10:00 a.m. in the Arafah Conference Room.

Section 2: Credentials and Required Categories



ARTICLE VI. ORGANIZATION OF THE MEDICAL STAFF **From the Medical Staff By-Laws**

Section 1 – Categories of Medical Staff Membership

The Medical Staff shall consist of (1) Active members, (2) Adjunct members and (3) Advanced Practice Registered Nurses, and (4) Physician Assistant members.

1. **Active Members:** The Active members shall consist of physicians and dentists licensed to practice medicine or dentistry, respectively, in the State of Connecticut who are employed or contracted by the Department of Mental Health and Addiction Services to work at CVH. Only those physicians and dentists who work at least twenty (20) hours per week at the Hospital are eligible for Active membership, and such physicians and dentists shall have full voting privileges and may hold office in the Medical Staff organization.
2. **Adjunct Members:** The Adjunct members shall consist of the following categories:
 - A. **Associate Staff:** The Associate Medical Staff shall consist of physicians and dentists who are licensed to practice medicine or dentistry in the State of Connecticut and who are contracted to work at CVH for a limited period of time (e.g., Temporary Worker Retirees, Durational Workers) or who work at the Hospital less than twenty (20) hours per week. They shall be eligible to serve on committees and to vote on matters before such committees. They shall be ineligible to hold office in the Medical Staff organization.
 - B. **Consulting Staff:** The Consulting staff shall consist of physicians and dentists of recognized professional abilities who are engaged in specialized medical or dental practice. The duties of the Consulting Staff shall be to provide their services at the Hospital upon request of a member of the Medical Staff. The Consulting Staff shall not have voting privileges in the Medical Staff Organizations. They will not be required to serve on committees.

There are two categories of Consulting Staff, which are delineated by their clinical privileges as follows:

- i. Consultants privileged to provide consultation and treatment. These Consultants shall be privileged to provide consultation and treatment within the scope of their delineated clinical privileges, including writing orders and clinical findings in the patient's medical record.
- ii. Consultants privileged to provide consultation only. These Consultants shall be privileged to provide consultation within the scope of their delineated clinical privileges but shall document on a consultation form or separate consultation report and shall not write orders.

- C. Night and Weekend Duty Staff: The Night and Weekend Duty Staff shall consist of physicians employed by the Department of Mental Health and Addiction Services to provide after hours, holiday and weekend medical and psychiatric services at CVH. Physicians in this category shall not have voting privileges or be eligible to serve on committees.
3. Advanced Practice Registered Nurse Members: The Advanced Practice Registered Nurse members shall consist of Advanced Practice Registered Nurses licensed in the State of Connecticut and employed by the Department of Health and Addiction Services to work at CVH as an Advanced Registered Practice Nurse and provide direct clinical care. Only Advanced Practice Registered Nurses who work at least twenty (20) hours per week at the Hospital are eligible for membership, shall have voting privileges in committees and at Medical Staff meetings are eligible to hold Medical Staff office.

Physician Assistant Members: The Physician Assistant members shall consist of Physician Assistants licensed in the State of Connecticut and employed by the Department of Health and Addiction Services to work at CVH as a Physician Assistant. Only Physician Assistants who work at least twenty (20) hours per week at the Hospital are eligible for membership, shall have voting privileges in committees and at Medical Staff meetings and are eligible to hold Medical Staff

ARTICLE VIII. CREDENTIALING AND PRIVILEGING

From the Medical Staff By-Laws

Section 1 – Clinical Privileges

All physicians/dentists, holding unrestricted licenses in Connecticut and permitted by law and by CVH to provide patient care services independently within the facility, shall have delineated clinical privileges, i.e., each such physician/dentist shall have written permission to order and/or provide, without direction or supervision, certain specific medical or other patient care services within well-defined limits. Each application for appointment and reappointment shall contain a request for specific clinical privileges. Granting and renewal of such clinical privileges shall be recommended by the Executive Committee of the Medical Staff to the Governing Body and shall be based upon a careful review of the individual's credentials and performance by the Credentialing and Privileging Committee.

Physician consultants, optometrists, podiatrists, and other non-physician consultants will have delineated clinical privileges.

Only such clinical privileges as have been granted by the Governing Body, in accordance with these By-Laws, shall be conferred on the practitioner.

Section 2 – Emergency Privileges

In the case of emergency, any member of the Medical Staff, regardless of Medical Staff status or privileges, shall be permitted to do everything possible to save the life of a patient, using every facility of the community necessary, including calling for any necessary or desirable consultation. For the purpose of this section, an "emergency" is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

Section 3 – Disaster Privileges

As part of the Hospital's overall emergency preparedness plan, and only when the Hospital has activated the *Emergency Operations Plan*, volunteer physicians and licensed independent practitioners, whose services are required and who are not current members of the Medical Staff, may be privileged by the Chief Executive Officer or designee, upon recommendation by the President of the Medical Staff or Chief of Professional Services. These practitioners will be supervised by the Chief of Professional Services through the Division Medical Directors. All practitioners with disaster privileges will be mentored and supervised through direct supervision and chart review in order to evaluate each practitioner's professional performance. When the *Emergency Operations Plan* is activated and during the immediate disaster period, privileges may be granted upon presentation of a current government issued identification card and one or more of the following:

- Current picture hospital/health organization identification card
- Current license to practice as an independent practitioner in the State of Connecticut
- Identification that the individual is a member of a Disaster Medical Assistance Team, Medical Reserve Corp (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) or has been granted authority to render patient care in disasters by a federal, state or municipal entity
- Confirmation by a current Medical Staff member of the volunteer's ability to act as a practitioner during a disaster

A Hospital issued Disaster Volunteer badge will serve as the volunteer's identification during the disaster. Primary source verification of licensure begins as soon as the immediate situation is under control and is completed within 72 hours from when the practitioner was granted disaster privileges. In the extraordinary circumstance that primary verification of licensure cannot be completed within 72 hours, it will be done as soon as possible. If primary verification of licensure is unable to be completed within 72 hours the following documentation will be required: the Chief Executive Office or Chief of Professional Services must possess documentation of the following: why primary verification could not be performed in the required timeframe, evidence of demonstrated ability to continue to provide adequate care, treatment and services and what attempts have/will be done to rectify the situation. If able to convene, within 72 hours, the Governing Body makes a determination (based on all information obtained regarding the professional practice of the practitioner and the status of the disaster event) to continue or terminate the granted disaster privileges.

Section 4 – Interim Clinical Privileges

When necessary for important patient care needs, interim clinical privileges may be granted by the Chief Executive Officer (or designee) at the request of the President of the Medical Staff (or designee), and based on the recommendation of the Chair of the Credentialing and Privileging Committee (or designee) for up to one hundred and twenty (120) days. The interim privileges may be granted only upon verification of the following:

- Current licensure
- Current competence

Interim privileges may also be granted in the case of a new applicant with a complete application that raises no concerns and is awaiting review and approval of the Medical Staff Executive Committee and the Governing Body. In this case, interim (temporary) privileges may be granted only upon verification of the following:

- Current licensure
- Relevant training or experience
- Current competence
- Ability to perform the privileges requested

- A query and evaluation of the NPDB (National Practitioner Data Bank) information
- A query of the Office of Inspector General for any pending or current adverse actions
- A complete application
- A current government issued photo identification
- No current or previously successful challenge to licensure or registration
- No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges
- Other criteria required by the organized Medical Staff By-Laws

Section 5 – Advanced Practice Registered Nurse Credentialing

The Advanced Practice Registered Nurse will be credentialed to perform designated clinical activities within the context of a collaborative agreement with a licensed physician who is an Active Member of the Medical Staff. Advanced Practice Nurses do not require co-signatures.

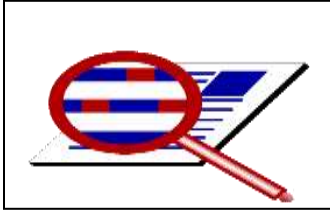
Section 6 – Physician Assistant Credentialing

The Physician Assistant will be credentialed to perform designated clinical activities under the supervision of a licensed supervising physician who is an Active Member of the Medical Staff. These responsibilities are enumerated in Operational Policy and Procedure “Ambulatory Care Services: Physician Assistants.” The Physician Assistant requires co-signatures on Schedule II and III medications within 24 hours of prescribing.

Section 7 – Resignation

1. A Medical Staff member wishing to resign shall submit a letter of resignation addressed to the President of the Medical Staff (or their designee), no less than thirty (30) days prior to his/her desired date of departure. This letter is shared with the Chair of Credentialing and Privileging Committee.
2. The President shall present such a letter to the Executive Committee of the Medical Staff for recommendation on the status of the resignation: accepted in good standing, accepted in conditional standing or accepted not in good standing. The recommendation of the Executive Committee of the Medical Staff will be forwarded to the Chief Executive Officer, or designee, for Governing Body review and final determination of acceptance and status of resignation.
3. For any Medical Staff credentialed and privileged clinician who is terminated from Connecticut Valley Hospital service secondary to a disciplinary action through the Labor Relations Division of the Human Resources Department; the Executive Committee of the Medical Staff will recommend to the Governing Body that the clinician’s privileges be terminated.

Section 3: Process for Initial Appointment



Credentialing and Privileging Process

The privileging process takes place at the time of hiring, appointment, reappointment (which occurs every two years), granting of Interim Temporary Privileges and the request for additional privileges. Resignations are reviewed as needed.

Initial Process for New Applicants

The Medical Staff Office is notified of a new hire, an application packet is put together by the Medical Staff Office Coordinator and sent out via US Mail, e-mail or fax.

The initial application packet includes:

- New applicant application
- Health Form
- Acceptable CPR information sheet
- Core Privilege Application and/or Specialty Privilege form
- Delineation of Privileges for each privilege requested
- New applicant letter
- Current copy of By-Laws and Rules and Regulations
- Pharmacy form

Once the application is received in the Medical Staff Office, complete and with required documents:

1. Past employer reference letter and questionnaires are sent out along with the Release of Information Consent Form and the Delineation of Privilege form(s). It is our policy to go back to every employer from completion of Residency to the present. Gaps in employment should be explained.
2. Peer Recommendation letters and forms are sent out along with the Release of Consent form. One peer must be in the practitioner's specialty.
3. Request National Data bank for NPDB/HIPDB reports. ***“The hospital and its Medical Staff shall comply with the requirements of the Health Care Quality Improvement Act of 1986 by reporting adverse actions and obtaining necessary information from the National Practitioner Data Bank” (Page 11, Article 6, Subsection 5 of the Medical Staff By-Laws).***
4. Verify Medical License via Internet. The verification is printed, signed and kept in the credentialing file. There is no grace period for expired Medical Licenses. Practitioners are pulled from clinical duty until the license is renewed.*
5. Verify the Connecticut Controlled Substance Registration via Internet. The verification is printed, signed and kept in the credentialing file. There is no grace period for expired Connecticut Controlled Substance Registrations. Practitioners are unable to write orders without a co-signature until it is renewed.*

6. Verify DEA via the Internet. The verification is printed, signed and kept in the credentialing file. There is no grace period for expired DEA Registrations. Practitioners are unable to write orders without a co-signature until it is renewed.*
7. The AMA profile is requested via the AMA website. Verify education, Residency, Internship, Fellowship and Boards.
8. If medical licenses were held in other states, verification is attempted.
9. OIG is queried for sanctions; print out the response, sign and date.
10. Residency, Internship and Fellowship is verified by sending the appropriate questionnaire and Release of Information Consent Form. If there is no response from a school that is closed or out of the country, there is no need to follow-up. A note is kept in the file indicating that there was no response. **These items can be verified on the AMA.**
11. If the applicant supplied a copy of an ECFMG, **verify via website of the ECFMG Verification Service.**
12. Applicant identification is taken in the form of a valid driver's license or US Passport. The photocopy is signed off and dated.
13. Verify current CPR. If the applicant completes CPR certification during orientation, note the date on the checklist. If it is expired, the applicant may not do clinical work until the CPR is complete.
14. Prepare the Record of Action and Checklist. Review and check-off items received.
15. Once all the credentialing material is received, the MSO reviews and signs off as complete. Any questionable items are noted and pointed out to the Chair, Chief of Staff, Chief of Professional Services and the reviewer to be brought up and discussed at the meeting.
16. **The appropriate Medical Director, or if the applicant will be in a Medical Director position, in which case the Chief of Staff or Chief of Professional Services, is called to review the file, any issues and sign off on the Health Request Form and Privileging Request Form. In the event that a Medical Director is unable to sign off on said forms, the Chief of Staff or Chief of Professional Services may do so.**
17. A member of the Credentialing committee is called upon to review the file. The reviewer will note any concerns or missing items they discover.

The application is now ready to be presented to the C&P Committee

18. **The Physician Member of the Credentialing and Privileging Committee will present the file for recommendation at the scheduled meeting.** Upon approval, the Chair will sign off in the C&P approval section and on the C&P Checklist.
19. Approved physicians are added to the next ECMS agenda. In the event a file is not approved, a particular privilege is denied, or the file is deferred until the next meeting for clarification of issues, the applicant is notified by the Chair of the committee to discuss the reasons why and what steps need to be taken. In the event that it is of a serious nature, the Chief of Professional Services will address the applicant.
20. Upon approval at ECMS, the President of the Medical Staff will sign off on the ECMS approval line.
21. The files are then requested to be added to the next Governing Body agenda. Upon Governing Body approval, the appropriate Granting of Privileges letter is generated by the MSO and given to the Chief Executive Officer (CEO) or designee for signature. They also sign the Governing Body approval section on the Record of Action.
22. Pharmacy is notified of the new member's DEA, Connecticut Controlled Substance Registration number and Medical/ Physician Assistant, RN/APRN license number and copy of the new member's signature.

***It is only necessary to keep verifications on file from the Primary Source Verification website.**

Section 4: Process for Interim Temporary Privileges



The Medical Staff Office is notified of a new hire, an application packet is put together by the Medical Staff Office Coordinator and sent out.

The initial application packet includes:

- New applicant application
- Health Form
- Acceptable CPR information sheet
- Core Privilege Application or Specialty Privilege form
- Delineation of Privileges for each privilege requested
- New applicant letter
- Current copy of By-Laws and Rules and Regulations
- Pharmacy form

Upon receipt of the completed application and verification of at least the most recent employer verifying competency; (3) peer recommendations, one of which must be in the practitioner's specialty; a clean NPDB/HIPDB, OIG and license verifications, the file can go forward. Interim Temporary Privileges are granted upon the recommendation of the Chief of Professional Services as designee of the Chair of the Credentialing and Privileging Committee. They are based on the request of a Medical Director who requests them, in writing, to the Chief of Professional Services based on urgent patient care need.

The Chief of Professional Services generates a letter with the request to the President of the Medical Staff. The President of the Medical Staff then generates a letter to the CEO for approval as Chair of the Governing Body.

Upon approval from the CEO, the acceptance letter is generated with the acceptance form and sent to the applicant.

The rest of the credentialing information is gathered and any questions are brought forward.

The file then goes through the regular credentialing process.

Section 5: Process for Reappointment Process



Reappointment Process

“Each member shall be considered for reappointment by the Executive Committee of the Medical Staff every two (2) years.” (Page 12 Section 2 of the By-Laws).

Approximately 4-5 months before a term expires, a reappointment packet is sent by the MSO. This packet will include the following:

- Reappointment application
- Reappointment letter
- Health Form
- CME Form
- Committee and Peer Reference list form
- Release of Information Consent Form
- Delineation of Privileges for each privilege requested
- Information Update Form
- Pharmacy Form (renew signature)

Once the application for reappointment is received:

1. If the applicant is an ACS doctor, the ACS Supervisor Recommendation is sent to the ACS Medical Director. (Currently, the COPS is providing this information.)
2. Peer Recommendation letters and forms are sent out along with the Release of Consent form. One peer must be in the practitioner’s specialty.
3. Request National Data bank for NPDB/HIPDB reports. ***“The hospital and its Medical Staff shall comply with the requirements of the Health Care Quality Improvement Act of 1986 by reporting adverse actions and obtaining necessary information from the National Practitioner Data Bank” (Page 11, Article 6, Subsection 5 of the Medical Staff By-Laws).***
4. Verify Medical License via Internet. The verification is printed, signed and kept in the credentialing file. There is no grace period for expired Medical Licenses. Practitioners are pulled from clinical duty until the license is renewed.*
5. Verify the Connecticut Controlled Substance Registration via Internet. The verification is printed, signed and kept in the credentialing file. There is no grace period for expired Connecticut Controlled Substance Registrations. Practitioners are unable to write orders without a co-signature until it is renewed.*
6. Verify DEA via the Internet. The verification is printed, signed and kept in the credentialing file. There is no grace period for expired DEA Registrations. Practitioners are unable to write orders without a co-signature until it is renewed.*

7. The AMA profile is requested via the AMA website. Verify education, Residency, Internship, Fellowship and Boards.
8. Check the OIG Website for sanctions.
9. ECFMG verification is not required for reappointment. It is a one-time verification
10. Verify current CPR. If it is expired, the applicant may not do clinical work until the CPR is complete, unless a letter certifying competency by the Medical Director or Chief of Professional Services granting a 30-day grace period is filed. There is no grace period beyond 30-days unless there is proof of a medical condition. In this case, other arrangements must be made.
11. Prepare the Record of Action and Checklist. Review and check-off items received.
12. Once all the credentialing material is received, the MSO reviews and signs off as complete. Any questionable items are noted and pointed out to the Chair, Chief of Staff, Chief of Professional Services and the reviewer to be brought up and discussed at the meeting.
13. The appropriate Medical Director, or if the applicant will be in a Medical Director position, in which case the Chief of Staff or Chief of Professional Services, is called to review the file, any issues and sign off on the Health Request Form and Privileging Request Form. In the event that a Medical Director is unable to sign off on said forms, the Chief of Staff or Chief of Professional Services may do so.
14. A member of the Credentialing committee is called upon to review the file. The reviewer will note any concerns or missing items they discover.
15. The Physician Member of the Credentialing and Privileging Committee will present the file for recommendation at the scheduled meeting.
16. Upon approval, the Chair will sign off in the C&P approval section and on the C&P Checklist.
17. Approved physicians are added to the next ECMS agenda. In the event a file is not approved, a particular privilege is denied, or the file is deferred until the next meeting for clarification of issues, the applicant is notified by the Chair of the committee to discuss the reasons why and what steps need to be taken. In the event that it is of a serious nature, the Chief of Professional Services will address the applicant.
18. Upon approval at ECMS, the President of the Medical Staff will sign off on the ECMS approval line.
19. The files are then requested to be added to the next Governing Body agenda. Upon Governing Body approval, the appropriate Granting of Privileges letter is generated by the MSO and given to the Chief Executive Officer (CEO) or designee for signature. They also sign the Governing Body approval section on the Record of Action.
20. MSO fills in the notification dates at the bottom of the Record of Action.
21. Pharmacy is notified of the new member's DEA, Connecticut Controlled Substance Registration number and Medical/ Physician Assistant, RN/APRN license number and copy of the new member's signature.

***It is only necessary to keep verifications on file from the Primary Source Verification website. It is noted that the MSO reminds the medical staff two months prior and regularly after that to renew licenses to help to avoid lapses.**

Section 6: Process for Additional Privileges



When additional privileges are requested by a practitioner, or change in status, etc. (on-call or other), the following form is submitted:

1. A signed Request for Privileges.
2. Once this form is received, the MSO obtains a new AMA, NPDB/HPDB and OIG profile on the practitioner.
3. The Medical Director is asked to review the request and sign-off.
4. If it is for on-call, the practitioner, is requested to have a brief review with the ACS Medical Director who then signs off on competency in Medicine.
5. Upon completion of this information, the Record of Action and Checklist is prepared.
6. The Credentialing physician review will present the file for recommendation at the scheduled meeting.
7. Upon approval, the Chair will sign off in the C&P approval section and on the C&P Checklist.
8. Approved physicians are added to the next ECMS agenda. In the event a file is not approved, a particular privilege is denied, or the file is deferred until the next meeting for clarification of issues, the applicant is notified by the Chair of the committee to discuss the reasons why and what steps need to be taken. In the event that it is of a serious nature, the Chief of Professional Services will address the applicant.
9. Upon approval at ECMS, the President of the Medical Staff will sign off on the ECMS approval line.
10. The files are then requested to be added to the next Governing Body agenda. Upon Governing Body approval, the appropriate Granting of Privileges letter is generated by the MSO and given to the Chief Executive Officer (CEO) or designee for signature. They also sign the Governing Body approval section on the Record of Action.

Section 7: Connecticut Controlled Substance Registration



This registration permits practitioners to distribute, dispense, conduct research, administer, or procure controlled substances in the course of their professional practice as permitted by the Department of Public Health or other governing agency.

Practitioners include but are not limited to:

- Medical Doctors (MD)
- Osteopaths (DO)
- Dentists (DDS, DMD)
- Veterinarians (DVM)
- Advanced Practice Registered Nurses (APRN)
- Physician Assistants (PA)
- Scientific Investigators

Please Note: This is a mandatory requirement for licensed medical personnel who prescribe controlled substances in Connecticut. All registrations expire biennially on February 28th of every odd-numbered year.

This license is verified at appointment, yearly renewal of licensure and reappointment. We do not recognize a grace period for this license.

Section 8: Medical License

In order to be eligible for Connecticut physician licensure, all applicants must have:

Graduated with the M.D. or D.O. degree from a medical school accredited by the Liaison Committee on Medical Education ([LCME](#)) or the American Osteopathic Association ([AOA](#)); completed at least two (2) years of progressive, post-graduate medical training as a resident physician in a program accredited by the Accreditation Council for Graduate Medical Education ([ACGME](#)) or the American Osteopathic Association ([AOA](#));

Successfully completed one of the following examinations:

- A State Board Licensing examination completed prior to June 1, 1979;
- United States Licensing Examination ([USMLE](#));
- National Board of Medical Examiners ([NBME](#));
- Federation Licensing Examination ([FLEX](#));
- National Board of Osteopathic Medical Examiners ([NBOME](#));
- The examination required to become registered as a Licentiate of the Medical Council of Canada ([LMCC](#)); or
- An acceptable combination as outlined below if completed prior to 2000:

NBME Part I or USMLE Step 1
plus
NBME Part II or USMLE Step 2
plus
NBME Part III or USMLE Step 3

FLEX Component 1
plus
USMLE Step 3

NBME Part I or USMLE Step 1
plus
NBME Part II or USMLE Step 2
plus
Flex Component 2

Applicants who have completed the FLEX (Components 1 and 2) must have obtained a passing score of 75 on each component. Applicants who have completed the FLEX (Day 1, 2 and 3) must have obtained a FLEX-weighted average of 75. Part(s) of the NBOME plus segment(s) of FLEX or USMLE are not acceptable combinations for Connecticut licensure. An official transcript of medical education verifying the award of an M.D. or D.O. degree forwarded directly to DPH from the educational institution*; Verification of completion of at least two (2) years of progressive, post-graduate residency training submitted directly from the Chief of Staff/Program Director of the residency program(s).

Medical License is verified at appointment, yearly renewal of licensure and reappointment. We do not recognize a grace period for this license.

Section 9: DEA



Issuance of a DEA registration to prescribe controlled substances is predicated on successfully completing all of the requirements imposed by the state in which the practitioner will conduct business and obtaining a state license. If the practitioner fails to obtain the required state license or has the license revoked or rescinded, then the DEA cannot issue the requested registration. If an existing DEA registrant loses his/her state privileges, then the DEA must also rescind or revoke the federal authority to prescribe controlled substances.

The DEA Form 224 – New Application for Retail Pharmacy, Hospital/Clinic, Practitioner, Teaching Institution, or Mid-Level Practitioner has a space to list the Drug Schedules of controlled substances that the practitioner wishes to handle. The practitioner must be authorized by the state to handle those drugs for which he/she is applying for DEA authorization and accordingly will ONLY be authorized to handle those drugs that are checked on the application form.

Practitioner registrations must be renewed every three years.

A separate registration is required for each principal place of business or professional practice where controlled substances are stored, administered, or dispensed by a person. If a practitioner will only be prescribing from another location(s) situated within the same state, then an additional registration is not necessary.

A practitioner who moves to a new physical location must request a modification of registration. A modification is handled in the same manner as a new application and must be approved by DEA. A modification of registration can be requested online at www.DEAdiversion.usdoj.gov or by writing to the local DEA Registration Program Specialist responsible for the area in which the new office is located. If the change of address involves a change in the state, the proper state issued license and, if applicable, state controlled substances registration must be obtained prior to the request to DEA for an address change. If the modification is approved, DEA will issue a new certificate of registration. The registrant should maintain the new certificate with the old certificate until expiration.

This license is verified at appointment, at renewal time of licensure and reappointment. We do not recognize a grace period for this license.

Section 10: Office of Inspector General (OIG 0



The **Office of Inspector General** investigates complaints or allegations of wrongdoing or misconduct by employees or contractors that involve or give rise to fraud, waste or abuse within the programs or operations of the FCC

The **Office of Inspector General** is **responsible for** (1) conducting audits and investigations; (2) reviewing legislation; (3) recommending policies to promote efficiency and effectiveness; and (4) preventing and detecting fraud, waste, and abuse in the operations of the agency.

OIG maintains a list of all currently excluded **individuals** and entities called the List of Excluded **Individuals/Entities (LEIE)**. Anyone who hires an individual or entity on the LEIE may be subject to **civil monetary penalties (CMP)**.

The proper way to screen a healthcare employee or third party vendor includes an initial Office of Inspector General (**OIG**) **check** of the List of Excluded Individuals and Entities (LEIE). This should be done prior to the hiring of or commencement of billing for the services or items purchased from a third party vendor.

This data bank is queried upon appointment, reappointment or change in privileges. This data bank reports judgments against a practitioner in Federal or State Courts related to the delivery of health care service; Federal or State criminal convictions against a health care provider related to the delivery of health care service; Actions by Federal or State agencies responsible for the licensing and certification of health care practitioners, including: formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, ensure or probation.

- A) **Any other loss of license or the right to apply for, or renew, a license of the practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise.**
- B) **Any other negative action or finding by such Federal or State agency that is publicly available information.**

1) **Exclusion of health care practitioner from participation in Federal or State health care programs.**

2) **Any other adjudicated actions or decisions that the Secretary established by regulations.**

This website is checked at appointment, reappointment, change or addition of privileges.

Section 8: AMA Profiles



Physician Profile vs Physician Reappointment Profile The AMA Physician Profile (“full” or “initial” profile): comprehensive physician information, including education, training, board certifications, state license data and more.

The AMA Physician Reappointment Profile: verification of information that is subject to change, including state license(s), board certification(s), and other such data. Unchanging information, like education or ECFMG applicant number is not included.

All AMA Profiles assist in reducing the threat of clinical, legal, and financial liability for practitioners, payers, and health care organizations by helping to identify highly qualified health care professionals to serve the public. The AMA verifies with the primary source the following elements:

- Medical school
- Graduate medical education
- ABMS® specialty board certification (includes MOC)
- All state licensure data (current and historic) and sanctions
- DEA registration
- National Provider Identifier (NPI) number
- Education Commission for Foreign Medical Graduates (ECFMG) applicant number

AMA is an official licensee of American Board of Medical Specialties (ABMS®) data. As such, the AMA is designated as an official ABMS display agent and serves as a provider of primary source equivalent ABMS specialty board certification data. That data, which is updated monthly, includes the following:

- Specialty and subspecialty certification (certification type)
- Initial year granted (effective date)
- Expiration dates
- Reverification dates
- Duration
- Status (active or expired)
- Maintenance of certification

We run the AMA profile at time of Initial Appointment, Reappointment, request for additional privileges.

Section 9: National Practitioner Data Bank/Health Information Data Bank



These entities are queried upon appointment, reappointment or change in privileges. The NPDB/HIPD reports on malpractice payments, adverse licensure action, adverse clinical privilege actions, and adverse professional society membership actions. Information reported to the NPDB/HIPD is maintained permanently unless it is corrected or voided from the system (a correction or void may only be submitted by the reporting entity or directed by the Secretary of the HHS).

A data bank request is filled out on the data bank using the blank query form. Information is added, and the data bank queried.

Section 10: CPR Requirements



CPR Certification

Excerpted from the Medical Staff Rules and Regulations (Article XIV: Professional Development)

“All members of the Medical Staff except consultants are expected to maintain current certification in Cardiopulmonary Resuscitation (CPR), and must be CPR certified prior to performing direct patient care. The CVH, CPR course is the American Red Cross Adult CPR including “Standard First Aid with AED is only good for one year.” Only Advanced Cardiac Life Support (ACLS) can be substituted for the CVH mandated CPR course. Successful completion of the CVH CPR course satisfied the Medical Staff requirement for a one-year period. ACLS satisfies the requirement for two years.”

The following categories of the Medical Staff are required to maintain CPR certification:

- All on-call physicians
- Physician Assistants
- APRNs
- 120-day physicians (including Locum Tenens) who are unit based (whether on Active or Adjunct Status)
- All physicians other than consultants

Consultants are exempt from the CPR requirement and cannot be on the emergency response team.

If a new applicant in one of the Medical Staff categories for which CPR certification is required does not have acceptable CPR certification at the time of his/her application is being reviewed, arrangements will be made to have the individual receive appropriate CPR training as soon as possible. It is the responsibility of the Division/Department to assure that that staff member has completed the required in-service training programs commensurate with his/her assigned duties. At the divisional level, education coordinators should assure that physician’s training is up-to-date. The Divisional Service Medical Directors assure that this is the case.

The Medical Staff bears the responsibility of clarifying to the Departments of Human Resources and Staff Development what a given Medical Staff member’s in-service requirements are.

Section 11: Cardiopulmonary Resuscitation, First Aid and Automatic External Defibrillator use



All medical staff who are privileged to provide direct patient care must receive either annual training or provide annual proof of satisfactory completion of a “re-challenge” test in order to receive certification in **adult CPR, basic first aid, and the use of the automatic external defibrillator.**

The DMHAS Department of Safety Services (DSS) provides trainers at each DMHAS facility so that each facility can meet its mandatory training requirements. All on-site CVH-employed medical staff are required to meet the CVH training requirements through a schedule of training opportunities arranged through his/her Division or Department.

Those members of the medical staff who provide “on-call” (after hours and weekend coverage) can meet this obligation by one of several methods:

- Being scheduled into one of the Division’s courses (through one’s Supervising Medical Director);
- Contacting the DSS trainer at CVH (telephone (860) 262-5451 or 5172) to arrange an appointment for a personal re-challenge.
- Contacting a DSS trainer at a DMHAS facility more proximate to one’s home/regular place of work to arrange an appointment for a personal re-challenge.
- Successfully completed an American Red Cross “Standard First Aid with AED” course and providing a certificate of proof.

Proof of satisfactory completion of this three-part annual training must be presented as a part of the Application for Appointment/Reappointment to the Connecticut Valley Hospital Medical Staff. This is done yearly.

The only other program that meets the CPR requirement is: ACLS American Red Cross (Advanced Cardiac Life Support) – two (2) year certification.

Section 12: CME Requirements



Excerpted from the Medical Staff Rules and Regulations (Article XIV: Professional Development)

ARTICLE XV: PROFESSIONAL DEVELOPMENT

1. There shall be a working medical library and journal file.
2. All members of the Active Medical Staff shall be encouraged to continue their professional development through in-house training opportunities, recognition and pay incentive or passing specialty boards, and an opportunity to receive additional training in areas found deficient through peer review mechanisms. Additionally, all members are encouraged to attend courses and conferences related to clinical or administrative work. It is expected that each Medical Staff member earn one hundred (100) continuing education credits per two-year period, at least forty (40) credits being category one credits. It is understood that resident physicians performing night & weekend duty shall satisfy this requirement by means of their documented continued participation in an ACGME approved residency training program. The Continuing Medical Education Committee shall arrange for appropriate educational opportunities to be held at the Hospital.
3. All members of the Medical Staff except consultants are expected to maintain current certification in Cardiopulmonary Resuscitation (CPR), and must be CPR certified prior to performing direct patient care. The CVH CPR course is the American Red Cross Adult completion of the CVH CPR course satisfies the Medical Staff requirement for a one-year period. Advanced Cardiac Life Support (ACLS) satisfies the requirement for two years.
4. All members of the medical Staff endorse the concept of "best practice" and support the development and implementation of selected "practice guidelines" at both the facility and agency level.

Section 13: License Updates/Expirations



A master list of all expirations being tracked is kept by the MSO. This list includes (and may expand as necessary):

- Privilege expiration date
- Medical license expiration date
- CPR expiration date
- DEA expiration date
- CT Controlled Substance Registration expiration date
- OPPE/FPPE due date

This list is reviewed **weekly and monthly, or as needed**, to identify at least two months ahead of time, those expirations coming due. A reminder e-mail is sent to each doctor to remind them of the upcoming expiration and to urge them to renew the license before the expiration date to avoid lapse in coverage.

It is no longer required to submit copies of renewed licenses as the printed and signed copy from the Primary Source Verification from a JCAHO approved website is sufficient.

If verification of renewal is not received or able to be verified, the appropriate Medical Director is contacted. If still not action is taken, the Chief of Professional Services and the Chief of Staff are notified for further action. **(Possible relieving of duties until renewal can be verified). Other than for CPR certification, there is no grace period on an expiration date.**

Section 14: Delinquencies



Medical Staff Delinquencies

It is the policy of the Credentialing & Privileging Committee that effective January 1, 2002, various delinquencies on the part of Medical Staff members will be viewed more seriously, and certain steps will be taken at the time of reappointment.

Potential delinquencies include:

- Attendance at less than 50% of Medical Staff meetings by full-time Active members, or less than 25% of meetings by part-time (25 hours or less weekly) Active members [Bylaws, Article XII]
- Attendance at less than 50% of assigned Committee meetings by full-time Active members, or less than 25% of meetings by part-time (25 hours or less weekly) Active members [Bylaws, Article XII]
- Less than 40 Category One CME credits per two year period, or less than 100 total CME hours per two year period [Rules & Regulations, Article XV]
- Excessive Delinquencies in Medical Record documentation, including timeliness of Admission Psychiatric Evaluations, Integrated Clinical Summaries, Annual Psychiatric Reviews, Discharge Summaries, and legible Progress Notes [Rules & Regulations, Article IV]. The Credentialing & Privileging Committee will evaluate cases of Medical Record delinquency individually, and make a determination as to whether the physician's delinquencies are excessive.

Effective January 1, 2002, it became the policy of the Credentialing & Privileging Committee to first issue a warning letter at time of reappointment to each member of the Medical Staff who has been delinquent as described above. At the time of subsequent reappointment, the Medical Staff member, if still delinquent, will be recommended for reappointment for only a one year term, instead of the regular two year period. It is also understood that such matters will be referred to the applicable Medical Director for appropriate action [approved by Credentialing & Privileging Committee on 10/25/01; approved by Executive Committee of the Medical Staff on 11/1/01].

Percent attendance at Medical Staff meetings is calculated by dividing the meetings attended by the total number of meetings during the prior two years, without taking into account any excused absences [approved by Credentialing & Privileging Committee on 4/25/02; approved by Executive Committee of the Medical Staff on 5/2/02].

Section 14: Clinical Competency Peer References



In accordance with the various CVH Core Privileges, peer references verifying current clinical competence at the time of reappointment shall consist of:

Reappointment in Psychiatry:

Three letters of reference from members of the Connecticut Valley Hospital Medical Staff familiar with the applicant's current practice of psychiatry.

Reappointment in Medicine:

Three letters of reference from members of the Medical Staff familiar with the applicant's current practice of medicine.

Reappointment as Consultant in Psychiatry:

Three letters of reference from members of the Connecticut Valley Hospital Medical Staff familiar with the applicant's current practice of psychiatry.

Reappointment as Consultant in Psychiatry, Electroconvulsive Therapy:

Three letters of reference from members of the Connecticut Valley Hospital Medical Staff familiar with the applicant's current practice of electroconvulsive therapy.

Reappointment as Medicine Consultants:

Three letters of reference from members of the Connecticut Valley Hospital Medical Staff familiar with the applicant's current specialty practice.

For Psychiatrists and Ambulatory Care Physicians, at least one letter of reference (in addition to the Medical Director's Evaluation) shall be from a practitioner in the same area of practice.

For Medical Consultants (e.g. neurology, nephrology, infectious diseases, physiatry, podiatry, optometry, etc.), at least one reference shall be from a practitioner in the same specialty. If none are available on the CVH Staff, a practitioner outside the hospital may be used as a peer reference. If it is impossible to obtain any peer reference from a practitioner in the same specialty, then in addition to the usual three references, a letter shall be submitted by the Medical Director for Ambulatory Care Services documenting this and verifying current clinical competence in the specialty area.

Section 15: Ongoing Professional Practice Evaluation/Focused Professional Practice Evaluation



Ongoing Professional Practice Evaluation:

An ongoing professional practice evaluation is conducted for every member of the Medical Staff. The evaluation is carried out by the Medical Director responsible for supervising each practitioner, and in the case of the Medical Directors, it is carried out by the Chief of Professional Services.

A formal Competency Based Performance Appraisal or PARS is completed on a yearly basis and is forwarded to the Credentialing & Privileging secretary to be maintained on file. It is reviewed at the time of all reappointment and privileging decisions. A continuous, ongoing evaluation of each practitioner's professional performance is also carried out by the responsible Medical Director. It includes the following areas of general competencies:

- Clinical Skills / Competence and Patient Care
- Medical / Clinical Knowledge
- Clinical Judgment
- Interpersonal Skills
- Communication Skills
- Professionalism

The result of each ongoing evaluation, and whether it justifies the continuation, revision, or revocation of privileges, is communicated to the Credentialing & Privileging Committee at least every six months, and in any case immediately whenever a question arises as to a practitioner's professional competence and practice.

Focused Professional Practice Evaluation:

A focused professional practice evaluation will be conducted by the responsible Medical Director whenever an issue arises as to a practitioner's competence or provision of safe, high quality patient care. The matter will be reviewed by the Executive Committee of the Medical Staff, and possible limitation of privileges or required supervision instituted, pursuant to the procedure set forth in Article VIII of the Medical Staff By-Laws (Corrective Action and Appeal Mechanisms).

Effective January 1, 2008, a six month period of focused professional practice evaluation will be implemented for all initially requested privileges. The period may be extended if professionally warranted. The responsible Medical Director will carry out the evaluation using the standards of the Ongoing Professional Practice Evaluation. The results of the evaluation will be communicated by memo to the Credentialing & Privileging Committee at the end of six months, or earlier if indicated.

Approved by Credentialing & Privileging Committee 3/8/07
Approved by ECMS 4/5/07

Section 7 – Resignation



1. A Medical Staff member wishing to resign shall submit a letter of resignation addressed to the President of the Medical Staff (or their designee), no less than thirty (30) days prior to his/her desired date of departure. This letter is shared with the Chair of Credentialing and Privileging Committee.
2. The President shall present such a letter to the Executive Committee of the Medical Staff for recommendation on the status of the resignation: accepted in good standing, accepted in conditional standing or accepted not in good standing. The recommendation of the Executive Committee of the Medical Staff will be forwarded to the Chief Executive Officer, or designee, for Governing Body review and final determination of acceptance and status of resignation.
3. For any Medical Staff credentialed and privileged clinician who is terminated from Connecticut Valley Hospital service secondary to a disciplinary action through the Labor Relations Division of the Human Resources Department; the Executive Committee of the Medical Staff will recommend to the Governing Body that the clinician's privileges be terminated.

List of Medical Staff Office Duties/tracking



1. Continuously track the Medical License expiration dates
2. Track the renewal of CSR registrations (every 2 years they all come up for renewal)
3. Continuously track the DEA registration expirations/renewals.
4. Send reminders to those coming up for expirations (CPR, DEA, and Medical License), track response. Let Medical Directors know if there is no response, or if there is a problem.
5. Renew Pharmacy Forms for pharmacy (to track signatures) at time of reappointment (Easiest way; or do them once a year).
6. Track those doctors that have suboxone waiver
7. Track CPR expirations
8. Continuously track the privilege expiration dates. Reappointments should be done at the very least 2 months ahead of time, in case there are questions or problems with the files.
9. For ease of knowing right away who has what privileges, track changes on the expiration list. This enables you to have a resource to know right away, if asked what privileges people have.
10. Using the privilege expiration dates, send out applications, gather information, send out peer recommendations, school verifications, run reports, check licenses, etc., as detailed in the C&P Process. Follow all the way through to Governing Body, acceptance letter and acceptance form.
11. Process new applicants coming in (usually notified by COPS or HR). send out application, gather information, send out peer recommendations, school verifications, run reports, check licenses, etc., as detailed in the C&P Process. Follow through to Governing Body, acceptance letter and acceptance form.
12. Prepare items, agenda and follow-up for C&P meeting (binders, agenda, minutes, processes, forms, etc.)
13. Prepare items, agenda and follow-up for ECMS meetings (agenda, minutes, processes, schedule presenters.)
14. Put together quarterly report for C&P.
15. Gather and send quarterly report information to President of the Medical Staff for their quarterly report to ECMS.
16. Remind Medical Staff Committees that quarterly reports are due, schedule for presentation to the ECMS, and save to file on the "T" drive
17. Schedule Executive Sessions for ECMS.
18. Track Death Review through ECMS session, gather signatures and file.
19. Support Chair of Death Review Committee as needed.
20. Track OPPE/FPPE (currently at reappointment). Every six months for OPPE; FPPE for issues and/or new doctors done at 3 months; and then at 6.
21. Track board certifications and their renewals. Provide list to HR and COPS.
22. Get the yearly Physician Time Study dates (done quarterly). Send out the memo to Administrative Doctors (quarterly); gather their information; and put together the Administrative Time Study Report. Review the Medical Staff Physician Time Study Roster, make changes/additions as needed. Have Dr. Pisano review it, sign it and forward to Comptroller's Office. Keep an electronic copy in the file.
23. When employee verification comes in, give the file to COPS. Pull up the file from the "T" drive and e-mail it to COPS. Give him the hire date and the end date.
24. Signed verification forms are faxed to the entity requesting them. Once you receive the fax confirmation, scan it and file it in the practitioner's folder on the "T" drive. (Each doc has a file).
25. Residency verifications done similarly.

26. Print Staff Roster from “T” drive periodically and review that it matches the Expiration list for active docs; also note any new doctors coming in or those leaving.
27. Follow-up with COPS if you see new doctors on the Staff Roster as “coming” and you have not heard their name.
28. Make sure any docs coming on board are going through the C&P Process. A doctor cannot work without privileges.
29. At time of reappointment. Take out the last appointment from the back of the binder and scan and save to the physician’s file on the “T” drive. Move the current one to the back and start the new one. Put the new expiration date on the binder (another good way to cross check what you are doing).
30. Once a month print out summary from AMA, ECFMG, NPDB or other entity and send the information to reconcile the P-card.
31. Track electronic voting of the Medical Staff to By-law, Rules and Reg. changes and other votes
32. Keep passwords and memberships to the AMA, ECFMG, NPDB current and accurate. You need to be approved to be a user.
33. Track that 2 years of performance appraisals are kept in the C&P Binder. Older ones should be scanned into the doctor’s file on the “T” drive.
34. Prepare minutes, agendas, and follow-up work for ECMS, C&P, and Total Medical Staff.
35. Review and track on-call calendars for the hospital. Make changes, address open dates as needed with appropriate medical directors and COPS.
36. Prepare CMC agenda, and minutes. Attend meeting and take notes.
37. Gather Medical Staff Committee Rosters and track attendance for C&P purposes. Send out and gather committee participation information.
38. CVH Today (prepare and distribute).
39. Support COPS, as needed.
40. Have non-formulary requests signed off by COPS. Fax back to the prescribing unit, pharmacy and keep a copy in the notebook. Throw away after 3 months.
41. Prepare agenda, take minutes and process for the CMC meeting.(1x/month)
42. Prepare agenda, take minutes and process for the GSOC meeting. (1x/month)
43. Prepare agenda, take minutes and process for Credentialing and Privileging Committee meetings. (1x/month)
44. Prepare agenda, take minutes and process for the Executive Committee of the Medical Staff (ECMS) meetings (2x/month).
45. Prepare agenda, take minutes and process for Total Medical Staff (TMS) Committee meetings. (1x/month)



The Ideal Credentialing Standards: Best Practice Criteria and Protocol for Hospitals Taken from the NAMMS February 2014

Credentialing best practices include an evidence-based evaluation that verifies 13 specific criteria from primary sources. Secondary sources such as a credential verification from another facility, copies of a credential verification, or confirmation from a source that verified the credential should only be used if primary source queries are unattainable. All information to support the following 13 criteria should be primary-source verified within 120 days at the time of credentialing review.

Each health facility and system should establish specific qualifications for medical staff membership and clinical privileges that reflect practitioner competency. They should incorporate the 13 criteria that NAMSS has identified as the Ideal Credentialing Standards into its medical staff bylaws, rules and regulations, and other governance documents to ensure that its credentialing process is objective, systematic, and without discrimination or bias. Just as credentialing assesses an applicant's professional abilities outlined in licensing scopes of practice, it also detects professional incompetence, malevolence, behavioral problems, or other red flags that would deter a health facility and system from employing and credentialing an applicant. Although red flags do not automatically preclude a practitioner from the medical staff, Medical Services Professionals (MSPs) should perform a comprehensive review of a practitioner with any red flags, keeping in mind the relativity among different specialties, patient safety, and likelihood of lawsuits.

Examples of red flags:

- ☐ Resignation from a medical staff at any time in an applicant's career.
- ☐ Reports of problems in an applicant's professional practice.
- ☐ All past or pending state licensing board, medical staff organization, or professional society investigative proceedings.
- ☐ Unexplained or unaccounted time gaps.
- ☐ No response to a reference inquiry from an applicant's past affiliation.
- ☐ Disciplinary actions by medical staff organizations, hospitals, state medical boards, or professional societies.
- ☐ Any claims or investigations of fraud, abuse and/or misconduct from professional review organizations, third-party payers, or government entities.
- ☐ Little or no verified coverage from a professional liability insurance policy.
- ☐ Jury verdicts and settlements for professional liability claims (which should still be individually reviewed).
- ☐ Inability to maintain a medical practice within the facility's service jurisdiction for any amount of time.¹

Verifying the following 13 criteria will generate the information necessary to assess an applicant's professional competence and personal decorum as well as help identify red flags or the need for further investigation.

1. Proof of Identity

- Government-issued photo identification
- NPI number
- I-9 documentation listed as List A or List B or C as defined on form
- VISA card or Employment Verification card

A seemingly straightforward step, verifying a practitioner's identity with government-issued documentation and an identifiable photograph ensures that his/her identity is correct – the critical first step to the credentialing process. Valid government-issued photo identification, in addition to any of the following three documents listed above, can be used to verify an applicant's identity.

Primary Sources: Government-issued identification.

2. Education and Training

- Complete list (domestic and foreign) of medical school, internship, residency, and fellowship enrollment and completion dates, as well as clinical degrees and other relevant experience in MM/YY format
- Completion status
- Explanation of any time gaps
- Fifth Pathway certification, if applicable
- ECFMG validation

All listed education and training entities that confirm training or education from medical school and beyond must include start and end dates. Applicants are required to submit a written explanation of any time gap greater than 90 days. Time gaps shed light on details of an applicant's education and training experience that are not explicit in self-reported materials. Explanations of these gaps, or lack thereof, may provide insight into an applicant's past that may be critical to the credentialing decision/recommendation.

Primary Sources: National Student Clearinghouse, AMA, AOA, ECFMG, and applicable professional schools or residency training programs.

3. Military Service

- DD214 if recently discharged; comprehensive list of military experience, including military branch and enlistment dates, if currently serving

Similar to education and training history, verifying an applicant's military experience provides insight into an applicant's training and work history – and overall professional competency. The details derived from the above information provide a thorough overview of an applicant's training history and performance. Enlistment time gaps may not be as straightforward as education and training gaps, but should not be overlooked and may require further investigation, including a written explanation by the applicant.

4. Professional Licensure

- Complete list and/or copies of all professional licensure including the issuing state, license type, license number, status, and issue and expiration dates

The applicable state licensing agencies primary source verify the validity, dates, and status of licenses listed on an application. Licenses obtained, held, and/or rescinded shed further light on an applicant's professional competency, performance, experience, and demeanor. Obtained licenses certify an applicant's ability to practice within the scope of each license held. Rescinded licenses provide insight into an applicant's history and may require further investigation such as a written explanation from the applicant.

A practitioner must be licensed in the states in which he/she practices. MSPs should directly investigate surrendered licenses or license sanctions, restrictions, revocations, suspensions, reprimands, or probations that the licensing entity or the National Practitioner Data Bank (NPDB) verifies.

Primary Sources: State licensing boards, FSMB.

5. DEA Registration and State DPS and CDS Certifications

- Complete list and/or copies of DEA, DPS, and/or CDS certificates including issuing state, status, registration number, and issue and expiration dates

The U.S. Drug Enforcement Agency (DEA) confirms an applicant's DEA certification, as well as the states in which the applicant is certified to prescribe, dispense, or administer controlled substances at the time of the credentialing assessment. The listed DEA address must match the state in which the applicant practices. Applicants in states that require a specific license or certificate to dispense, prescribe, or administer controlled substances must obtain Departments of Public Safety (DPS) and/or Controlled Dangerous Substance (CDS) certifications and abide by each state's rules, regulations, and renewal policies.

Primary Sources: DEA, National Technical Information Service, state DPS, state CDS.

6. Board Certification

- Complete list of Board-specialty certifications held including original dates, recertification dates, and expiration dates

The applicable certifying Board is the primary source for this verification. Board-certification verification must adhere to specific state requirements, if applicable. Physicians may be required to be active members of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA), or be an active candidate for the applicable board-certification exam.

7. Affiliation and Work History

- Chronological, comprehensive list of all facilities in which a practitioner has worked or held clinical privileges (e.g. academic appointments, hospitals, practice groups, surgery centers, etc.), including start date, date on staff, employment or staff status, verification of good standing, and end date
- Explanation of any time gaps

A practitioner's application and resume/CV should be checked against a primary source. A practitioner in good standing should have no adverse professional review action taken by an employer or work affiliation. The Health Care Quality Improvement Act defines "adverse actions" as "reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in a health care entity." Good standing asserts that neither the practitioner's staff membership nor clinical privileges have been reduced, restricted, suspended, revoked, denied, or not renewed.²

Applicants must provide a written explanation for any work history time gaps greater than 30 days. Affiliation history should include the start and end months and years (MM/YY-MM/YY). The start and end year is sufficient for applicants affiliated with a specific employer for more than five years (YYYY-YYYY).

Primary Sources: NAMSS PASS or verification from applicable facilities.

8. Criminal Background Disclosure

- Federal, state, and county databases

Background checks include conducting a County Criminal Search and National Criminal Search to check an applicant's criminal activity within at least the past seven years. MSPs must query each County Criminal Search for all counties in which the applicant has resided and worked. Collectively, the County and National Criminal Searches use an array of databases to collect information such as sex-offender data and terrorist activity.

Frequent adverse incidents throughout an applicant's work history, felony convictions, criminal history, and rehabilitation history may require additional, more extensive review. Criminal background checks should occur during initial credentialing and every four years thereafter, or according to state law.

Primary Sources: National, state, and county criminal databases.

9. Sanctions Disclosure

- Federal and state, if applicable

Temporary and permanent sanctions or licensure restrictions are relevant. Explanations should accompany any sanctions from certifying boards, payers, CMS, or licensing agencies. NPDB's Continuous Query issues alerts for new and monthly reports of all CMS sanctions, federal sanctions, state sanctions, and restrictions on licensure, certification, or scope of practice. The Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE) maintains and 5 National Association Medical Staff Services | February 2014 provides monthly updates on practitioners currently barred from participating in CMS and/or other federal healthcare programs. The General Services Administration's Excluded Parties List System (EPLS) and System for Award Management (SAM) monitor federal agency debarments, including those from OIG.

Although some of the above reported information may overlap with NPDB, LEIE is the primary database for exclusion screening for current and potential employees and contractors. Unlike the NPDB, which reinstates by revising original reports, LEIE and EPLS reinstatements purge the practitioner's original exclusion record. This may result in query inconsistencies, as an OIG exclusion may show up in the NPDB, but in neither the LEIE nor ELPS. *Primary Sources: NPDB, OIG, EPLS, SAM, FSMB.*

10. Health Status

Verifying whether the applicant has, or ever had, any physical or mental condition that would affect his/her ability to exercise the requested clinical privileges.

Primary Sources: Attestation from applicant, application.

11. NPDB

The NPDB provides healthcare-specific information on state and federal criminal convictions and civil judgments, as well as malpractice history and hospital sanctions. The Data Bank should be queried during the initial credentialing process and continuously thereafter through NPDB's Continuous Query Monitory Service. The latter step should be a part of the practitioner's enrollment process with the facility.

Primary Source: NPDB.

12. Malpractice Insurance

- Comprehensive list of insurance carriers, including coverage dates and coverage types
- List of open, pending, settled, closed, and dismissed cases
- Current certificate of insurance

The applicant should provide proof of all current and past malpractice insurance within at least the past five years, including coverage dates, coverage types, and policy numbers. MSPs should query relevant databases to verify the past five years of malpractice history and ascertain the background, status, and nature of any malpractice cases associated with the applicant.

Primary Sources: Self-reported verification, current and past malpractice carriers, NPDB

13. Professional References

- Professional references noting current competence

Professional authorities who have worked directly with the applicant within the past two years – such as training program directors and department chairs or chiefs – who can authoritatively speak to an applicant's experience, as well as peer references within the same professional discipline, are ideal references.

The Accreditation Council for Graduate Medical Education (ACGME) recommends six best-practice standards for assessing an applicant's competencies: patient care, medical knowledge, practice-based learning and improvement, systems-based practice, professionalism, and interpersonal skills and communication.³ Those providing references should consider ACGME's list when assessing an applicant's professional competencies.

Primary Sources: Letter signed and dated from the professional reference.