

 <p><b>HAWAII HEALTH SYSTEMS</b> CORPORATION <i>"Touching Lives Everyday"</i></p> <p><b>Policies and Procedures</b></p>	<p><b>Department:</b> Legal Department</p>	<p><b>Policy No.:</b> ADM 0022</p>
	<p><b>Issued by:</b> Rene McWade, Esq. VP &amp; General Counsel</p>	<p><b>Revision No.:</b> NA</p>
<p>Subject: <b>Credentialing Requirements</b></p>	<p><b>Approved by:</b> HHSC Board of Directors</p> <p>By: Raymond Ono Its: Secretary/Treasurer</p>	<p><b>Effective Date:</b> 4/17/2008</p> <p><b>Supersedes Policy: NA</b></p> <p><b>Page:</b> 1 of 9</p>

## I. PURPOSE

The purpose of this policy is to outline the requirements of credentialing for the facilities of Hawaii Health Systems Corporation (HHSC). All facilities of HHSC may further review, investigate, and verify any information in its possession in order to evaluate the applicant for membership and privileges in order to make a recommendation on an application. Additional credentialing information gathered beyond what is delineated in this policy is for the purposes of the inquiring facility only and may not be shared without written consent of the applicant. This policy defines the minimum requirements for all credential files submitted to a Governing Body of HHSC.

## II. DEFINITION

A Governing Body of HHSC includes the HHSC Corporate Board and all Regional System Boards.

## III. POLICY STATEMENT

All licensed independent practitioners (LIP) will submit an application for membership and/or privileges as required by this policy and medical staff bylaws. Privileges will be granted in accordance with applicable medical staff bylaws and privileging prior to providing patient care and exercising of clinical privileges.

The credentialing process will be compliant with requirements as set forth by federal and state statute, Centers for Medicare/Medicaid Services, and The Joint Commission regardless of the HHSC facility's current accreditation status.

## IV. PROCEDURE

Each application for appointment to the medical staff shall be in writing, submitted on the standardized HHSC credentialing form, and signed by the applicant. When an applicant submits a completed application form, a copy of the facility medical staff bylaws, rules and regulations, and copies of pertinent hospital and medical staff

policies and procedures relating to clinical practice in the hospital shall be made available.

**A. Application Content** - The application form requires information, which will include, but not be limited to, information concerning:

1. The applicant's qualifications, included but not limited to year and school of graduation, post-graduate training, including the name and years of each institution attended;
2. Documented clinical experience and current competency; this may include numbers and types of cases or procedures performed, if requested;
3. All past and current state license(s) held;
4. Specialty or sub-specialty board certification, recertification, or status in the certification process according to the particular requirements of the board;
5. Prior and current professional liability insurance coverage, including the names and addresses of present and past insurance carriers for the past 7 years;
6. Information on malpractice claim and suit history. This includes date of incident for which claim/suit was made, the allegation, the patient's condition, the applicant's role in providing treatment, the current status of the action, and supporting documents evidencing the status of the claim/suit. This information is to be provided on all claim/suit filings, settlements, judgments, awards, and dismissals (regardless of monetary payment, or lack thereof);
7. Selected personal information, such as home address and telephone number, date of birth, social security number, and citizenship;
8. Desired service affiliation, medical staff category assignment and specific clinical privileges requested;
9. Any current or past felony convictions;
10. Documentation as to an applicant's health status.
11. Any pending or completed challenges or actions involving denial, revocation, cancellation, suspension, reduction, limitation or probation of any of the following, and any non-renewal or relinquishment of or withdrawal (voluntary or involuntary) of an application for any of the following to avoid investigation or possible discipline or adverse action:
  - (a) Licensure
  - (b) Registration
  - (c) Medical staff membership

- (d) Clinical privileges
- (e) Federal DEA and/or state controlled substance registration;
- (f) Membership or fellowship in local, state, or national health or scientific professional organizations;
- (g) Appointment or employment status, prerogatives or clinical privileges at any other hospital, clinic, or health care facility since completion of post-graduate training;

**B. References**

1. The application shall include the names and contact information of professional references not newly associated or about to become partners with the applicant in professional practice or personally related to the applicant, who have personal knowledge of the applicant's current clinical ability, ethical character, health status and ability to work cooperatively with others and who shall provide specific written comments on these matters upon request from the Hospital or Medical Staff authorities.
2. The number of required references provided will be no less than two (2) for an initial appointment. References can be provided either in writing or verbally. Verbal references will include the name of the person calling, person contacted, number called, date and time called and summary of the interaction.
3. For reappointment, references can be obtained either by names provided by the applicant, or by members of the medical staff during its review and recommendation, provided that the medical staff feels it has had adequate opportunity review the performance of and evaluate the clinical competence of the applicant.

**C. Supporting Documentation** –The applicant must also provide:

1. An Education Commission in Foreign Medical Graduates (ECFMG) certificate (if applicable)
2. Copy of board certification (if applicable);
3. Certificates of completion of internship, residency, or fellowship (if applicable);

**D. Other Data Sources** – The Medical Staff office will query the National Practitioner Data Bank, Healthcare Integrity Practitioner Databank, The Office of the Inspector General List of Excluded Individuals-Entities, Excluded Parties Listing System, and other entities as deemed necessary by the Credentials/ Medical Executive Committees.

- E. Locum Tenens - Verification Credentialing Guidelines** – When applications for Locum Tenens are received, if the following criteria apply, facilities may use the guide below to complete verification requirements:

Applicant has greater than 20 locum tenens hospital affiliations:

1. All current hospital affiliations;
2. Past 5 locum assignments, regardless of length of privileges;
3. If placed on assignment by a locum firm, verification of assignment by the firm to include places and dates of assignment, statement of performance while on assignment;
4. Verification by each facility where the assignment was longer than 30 days over the past 7 years;
5. Verification of all licenses held, current and past.

- F. Processing the Application** – The applicant will deliver a completed application to the Medical Staff Office with advance payment of the application fee, when applicable. The Medical Staff Office will seek to collect and verify from the primary source, the training, experience, references, license status, insurance and claims history, DEA certification, board certification, and other evidence submitted or deemed necessary to support the application for membership and/or privileges. The Medical Staff Office will notify the applicant of any problems in obtaining supporting information and the applicant will bear the burden of obtaining the required information.

- G. Reappointment Process** – The Medical Staff Office shall provide each staff member a reappointment application for use in considering his or her reappointment approximately 6 months prior to the expiration of his or her current appointment. Each staff member who desires reappointment shall submit his or her completed reappointment application and all accompanying materials to the Medical Staff Office by the stated return date. Failure, without good cause, to so return the application and accompanying materials by stated date shall be deemed a voluntary resignation from the staff and shall result in automatic termination of membership at the expiration of the member's current term. A practitioner whose membership is so terminated shall refer to the Medical Staff Bylaws for Hearing/Appeals procedures.

- H. Content of Reappointment Application** – The reappointment application shall request data necessary to update the staff member's credentials file and shall include, but not limited to the following:

1. Updated demographic information.

2. Current license, DEA, liability insurance and board certification or recertification information (if not currently on file).
3. Name of the alternate coverage practitioner who will attend the staff member's patients during any absence, when required by medical staff bylaws.
4. A listing of all current hospital affiliations.
5. The name and address of one peer reference that can attest to the staff member's competency and character or has been responsible for professional observation of the staff member's performance.
6. A statement attesting to the continuing education received during the previous 2 years. Each facility may conduct an audit of CME activities if the facility deems it necessary.
7. Health screen information as to current TB testing, identification of any physical or mental condition which could affect ability to exercise clinical privileges requested or would require an accommodation in order to exercise the privileges requested safely and competently.
8. Such other specifics about the staff member's professional ethics, qualifications and ability that may bear on his/her ability to provide patient care in the hospital.
9. Special information including, but not limited to:
  - (a) Loss of board certification or failure to recertify;
  - (b) Actions against professional license or DEA certificate including but not limited to restrictions, limitations, denial, revocation, suspension, voluntary or involuntary surrender or cancellation;
  - (c) Convictions of a felony;
  - (d) Sanctions or charges by any government agency (i.e. Medicare, Medicaid, DEA), or any other medical reimbursement plan against the staff member, or their business associate for alleged inappropriate fees or quality of care issues;
  - (e) Present use of illegal drugs;
  - (f) Professional liability coverage that has been restricted, limited, denied or not renewed;
  - (g) Hospital, other healthcare facility, HMO, or health plan limitation, denial, suspension, revocation or restriction of professional privileges;
  - (h) Voluntary or involuntary relinquishment, limitation, or reduction of clinical privileges;

- (i) Withdrawal or failure to proceed with an application to avoid adverse action;
- (j) Professional liability judgments, claims filed, malpractice suits filed, pending and/or settlements against the staff member; information regarding the basis of the complaint/allegation and its current status must be provided by the applicant;
- (k) Citation for violation of ethical standards by a professional organization;
- (l) Voluntarily or involuntarily termination, suspension, restriction or revocation by Medicare, Medicaid, any third party payer or currently under investigation by any third-party payer;
- (m) Refusal or termination from participation by any HMO, PPO, or other alternative health care plan for cause;

10. A statement of acknowledgment, agreement, and release of information:

- I. **Verification of Information at Reappointment** – The Medical Staff Office, shall begin to collect and verify the additional information made available on each reappointment application and to collect any other materials or information deemed pertinent, including but not limited to information regarding:
  - 1. The staff member's professional activities at the hospital;
  - 2. Performance and conduct in the hospital and other hospital affiliations;
  - 3. His or her fulfillment of staff membership obligations;
  - 4. An assessment and recommendation from the medical staff;
  - 5. A National Practitioner Data Bank and Healthcare Integrity Practitioner Databank report;
  - 6. Malpractice claims and suit history activity; and
  - 7. A statement regarding the presence or absence of any indications of physical or mental health problems and/or impairment.
- J. **Delineation of Privileges** – Each facility will develop its own delineation of privileges forms based on the services provided by its hospital. Privileging forms will include minimum qualification criteria and a description of privileges, procedures, or scopes of practice as applicable. Delineation of privileges forms, and any amendments thereto, are subject to review and approval by the Governing Body.
- K. **Forms** – The forms utilized for verification of credentials will be standardized. Forms developed or modified will be reviewed and mutually approved by

Governing Bodies. All standardized forms will be made available for document generation via the credentialing database system (MIDAS).

- L. Regional Credentialing** – All appointments will be for effective periods. Providers with privileges at multiple HHSC facilities will have only one reappointment cycle that will be consistent throughout HHSC.

**M. Determination of Primary Organization**

1. Each provider will be assigned a primary organization. The primary organization will be responsible for processing reappointment applications, distribution of verified credentials to other facilities of HHSC, maintenance of data in Seeker, maintenance of current documents with expiration dates and distribution of such to other HHSC facilities (i.e. license, certificate of insurance, DEA, HI Narcotics Certificate, etc). The assignment of the primary organization will be made according to the volume of practice by that provider. However, if a provider specifically requests a HHSC facility to be designated as primary, that request will be honored.
2. Initial Application Processing – The organization that receives a complete application will process the application. It is strongly recommended that the facility search the Seeker system for information regarding that provider that may be on file. If an application is submitted to multiple HHSC facilities, verification of credentials should be processed at the facility that initiated processing first. It is imperative that facilities communicate to ensure there is no duplication of work.
3. Reappointment for Multiple Facilities
  - (a) The primary organization will initiate the reappointment process for all HHSC facilities at least six (6) months prior to the next reappointment date. The reappointment packet will include:
    - (i) Credentialing Worksheet (generated by MIDAS Seeker)
    - (ii) Reappointment questionnaire form
    - (iii) Consent and authorization form
    - (iv) Delineation of Privileges (DOP) request for each HHSC facility where privileged
  - (b) Upon completion of credentials verification, the primary organization will provide a copy of the completed packet to each facility where the provider is reapplying and that facility's DOP. NPDB reports will be run by the individual facility, or by their designated agent on behalf of the facility. Each facility must still conduct internal review & recommendation of a provider's application, to include any facility specific data.

**N. Medical Staff Review and Recommendation** – All applications will be reviewed and recommended to the Governing Body for final action by the medical staff. The review and recommendation process will be in accordance with medical staff bylaws.

**O. Submission of files to the Governing Body**

1. Process of approval

- (a) Upon completion of the verification of an applicant's credentials, each facility where the applicant is applying must conduct its own review of the application and request for privileges. Each facility medical staff must individually provide a recommendation to the Governing Body including the appointment category and delineated privileges.
- (b) Files will be submitted to the HHSC Legal Department, Attn: Director of Credentialing. The files will be reviewed for inclusion of all verified credentials, supporting documentation, and recommendations of the medical staff. If a file is not complete, the facility will be notified in writing or by phone of the deficiency and given an opportunity to provide additional information.

2. Deadlines

- (a) An annual schedule of meetings of the Board Credentials Subcommittee will be distributed amongst facilities. This schedule will include the date, time, mode of meeting, and the deadline for file submission.
- (b) Files not received by the date posted will be held until the next regular meeting of the Board Credentials Subcommittee. If a file is received before the deadline but is incomplete, the facility will be notified of missing information and pending items must be received by the stated deadline to be included in that month's agenda.
- (c) All completed files will be placed on the agenda for review by the Board Credentials Subcommittee and provided to its members at least 4 days prior to the meeting.
- (d) Following a favorable decision by the Subcommittee, the Board of Directors will ratify the committees' decision at its next regular meeting. If an adverse decision is likely, the Subcommittee will provide a report to the Board of Directors at its next regular meeting for final decision. The Subcommittee only has authority for favorable decisions of appointment and privileges. The list of approved files by the

Credentials Subcommittee will be provided to each facility as soon as possible following a meeting. If a file is presented to the Subcommittee, and not approved, the facility will be contacted to discuss the Subcommittee's decision.

- (e) Following notification of the approved files, each facility is will update the MIDAS system within 5 business days.
3. Transfer custodial control of credentialing to regional boards. Upon transfer of custodial control to regional system boards, the process for file submission to the Governing Body will be consistent with the processes outlined in Regional System Board bylaws and/or policy.