Credentialing and Privileging of Licensed Independent Practitioners

The following standards apply to individuals permitted by law and the organization to provide patient care services without direction or supervision, within the scope of their licenses and individually granted clinical privileges. These standards do not prevent the organization from credentialing and privileging individuals who work under supervision.

Standard HR.7
All individuals permitted by law and the organization to practice independently are appointed through a defined process.

Standard HR.7.1
Credentialing criteria are uniformly applied to licensed independent practitioners applying to provide patient care services for the organization.

Intent of HR.7 and HR.7.1
Mechanisms for appointment and reappointment are formally approved by appropriate leaders of the organization. (See LD.1.9.) The description of the mechanism is sufficiently detailed to permit tracking of the procedural steps involved when examining credential files.

Credentialing criteria specify requirements for practitioner membership in the organization. These criteria are designed to help establish an applicant’s background and current competence. Moreover, they are designed to help assure the organization and its patients that the patients will receive quality care. The core criteria are

- current licensure;
- relevant education, training, or experience;
- current competence; and
- ability to perform requested privileges.

Each credentials file demonstrates that criteria are uniformly applied and verified from primary sources.

Each organization develops its own criteria for determining an applicant’s ability to provide patient care services within the scope of clinical privileges requested. Criteria for renewal or revision of clinical privileges include procedure outcomes and other results of performance improvement activities.

The organization may elect to add other reasonable criteria, such as current evidence of adequate professional liability insurance, evidence of continuing medical education, and health status.

Appropriate documentation for each of the four essential criteria includes at least the following:

Current licensure. Current licensure is verified at the time of appointment and initial granting of clinical privileges. Verification can be accomplished by telephone or with a letter or computer printout from the appropriate state licensing board or from any state licensing board if in a federal service. Telephone verification of current licensure is documented. The organization has a way of ensuring that current licensure for all practitioners is verified and documented.

At the time of reappointment and renewal or revision of clinical privileges, current licensure is confirmed with the primary source or by viewing the applicant’s current license or registration.
Relevant training and experience. At the time of appointment and initial granting of clinical privileges, the organization verifies relevant training and experience from the primary source(s), whenever feasible. This includes letters from professional schools (for example, medical, dental) or residency or postdoctoral programs. For applicants who have just completed training in an approved residency or postdoctoral program, a letter from the program director is sufficient. Board certification in medical specialties is confirmed by the listings in the *Official ABMS Directory of Board Certified Medical Specialists*, published by the American Board of Medical Specialists (ABMS). If the applicant or organization uses a phrase such as "board qualified," such qualification is confirmed by a letter from the relevant ABMS specialty board.

Current competence. Current competence at the time of appointment and initial granting of clinical privileges cannot be determined by board certification or admissibility alone. Instead, it is verified in writing by individuals personally acquainted with the applicant’s professional and clinical performance, either in teaching facilities or in other organizations. Letters from authoritative sources provide the organization with information directly from the primary source(s). Such letters contain informed opinions about the applicant’s scope and level of performance. Acceptable letters are those that describe the applicant’s

- actual clinical performance in general terms,
- satisfactory discharge of professional obligations as a licensed independent practitioner, and
- acceptable ethical performance.

Ideally, letters also address at least the following two specific aspects of current competence:

1. For applicants doing operative or other procedures,
   - the types of operative procedures performed as the surgeon of record;
   - the handling of complicated deliveries; or
   - the skill demonstrated in performing invasive procedures, including information on appropriateness and outcomes.

   In the case of applicants in nonsurgical fields, the types and outcomes of medical conditions managed by the applicant as the responsible licensed independent practitioner should be addressed.

2. The applicant’s clinical judgment and technical skills. At the time of reappointment, current competence is determined by
   - the results of performance improvement activities,
   - peer recommendations, and
   - the individual’s professional performance, clinical judgment, and technical skills.

Peer recommendations (appropriate practitioners in the same professional discipline as the applicant—for example, physician, dentist, podiatrist—who have firsthand knowledge of the applicant) are in the credentials files and are part of the rationale for recommending appointment or reappointment and granting, renewing, or revising clinical privileges. If no peers on staff are knowledgeable about the applicant, a peer recommendation is obtained from outside the organization, such as from the local county or regional medical society, or a practitioner in the community or on the medical staff of a hospital or other health care organization. It is advisable, when possible, to include recommendations from an individual in the same specialty. Peer recommendations refer, as appropriate, to relevant training or experience, current competence, and how well the applicant fulfilled organization-specific obligations. Sources for peer recommendations may include:
- a performance improvement committee, the majority of whose members are the applicant’s peers;
- a reference letter(s) or documented telephone conversation about the applicant from a peer(s) who is knowledgeable about the applicant’s competence; and
- a department or major clinical service chair who is a peer.

**Ability to perform requested privileges.** The organization evaluates each applicant’s health status, but only in terms of ability to practice in the area in which he or she is seeking privileges. This evaluation is documented in the individual’s credentials file. Such documentation may include the applicant’s statement that no health problems exist that could affect his or her practice. Such statements are confirmed. When an applicant is applying for appointment or initial clinical privileges, the statement is confirmed by

- the director of a training program,
- the chief of services or chief of staff at a hospital at which the applicant holds privileges, or
- a currently licensed physician designated by the organization.

When an applicant is applying for reappointment or renewal or revision of clinical privileges, the statement is confirmed by at least a countersignature on the applicant’s statement by an individual having the authority to do so (for example, medical director).

**Examples of Implementation for HR.7 and HR.7.1**

1. The policies for the initial credentialing of applicants in a large multisite practice in the Pacific Northwest covered fully or in part physicians, dentists, dental surgeons, podiatrists, advance registered nurse practitioners, and physician assistants. When a practitioner was assigned to a single-specialty clinic in the county (for example, dental clinic, podiatric clinic), the credentialing process and policies were the same, but the practitioner’s privileges were specific to the setting in which services would be provided.

The policies also listed the following requirements:

- Each applicant completes an employment application (and attests to its accuracy) that includes information on licensure, education and training, liability and claims history, disciplinary action history, ability to perform requested privileges, work history, loss or limitation of clinical privileges, and malpractice insurance history and current coverage.
- Each provider submits to the medical or dental department copies of applicable professional licenses and DEA certifications.
- The primary sources of information on licensure, primary admitting facility, DEA certification, medical or professional school, residency, board certification, work history, malpractice insurance, and claims history are verified. In the case of licensure verification, many state licensing boards maintain web sites that can be used to verify licensure.
- Information is obtained from the National Practitioner Data Bank and Medicare and Medicaid about the applicant’s sanction history.
- Each provider signs a statement attesting to his or her ability to perform the requested privileges, with or without accommodation.
- The medical director reviews the application and supporting documentation and decides whether a provider may begin employment immediately. The medical director makes a recommendation to the board of directors for its review and approval of new practitioners within 90 days.
• Approval of a provider’s employment by the board of directors extends for a period of one year.
• The credentials file for each provider is maintained in a secure location to prevent unauthorized access and in order to protect both client and provider confidentiality.

The multisite practice also requires

• all prospective providers to present evidence that they are licensed and trained for the services they plan to provide;
• department of human resources staff to verify all applicants’ licensure, training, and experience;
• the board of directors to grant temporary privileges if the credentialing procedures have not yet been completed; and
• the board of directors to assume ultimate responsibility for making all initial appointments and reappointments and for assigning or curtailing clinical privileges.

2. Credentialing policies for physicians, dentists, physician’s assistants (PAs), and nurse practitioners at a large multi-site community health center specify that

• the community health center requires proof of current licensure at the time of employment and annually thereafter;
• each individual is responsible to obtain and maintain his or her license;
• the personnel director is responsible for monitoring the licensure status of all providers;
• all providers (medical and dental) post, in a prominent place, evidence of the license required to practice;
• all providers are responsible for obtaining continuing professional education credits for maintaining their licensure; and
• all providers must maintain the privileges necessary for fulfilling the scope of their job descriptions and the practice’s needs.

Additional policy statements addressing the practice of PAs and other midlevel practitioners state that

• PAs and other midlevels will function within the medical examining board rules or other appropriate rules;
• all patients with complex problems or difficult complications will be transferred to the care of physicians;
• each PA will have one physician as a primary sponsor and several alternatives with whom he or she will work whenever possible. Whenever the primary physician is not available to supervise a PA, an alternate physician will be identified for that time period. A physician will be available for consultation at all times;
• responsibilities of physicians working with PAs include cosigning all charts and ensuring that protocols are followed; authorizing and updating the midlevels’ approved exam, procedures, diagnoses, and prescription lists per the utilization plan; and supervising the development of an appropriate continuing medical education (CME) plan;
• midlevel staff will introduce themselves to patients, specifying who they are and their title (for example, “I am Mr Smith, physician assistant”);
• each midlevel staff member will have a standard letter of agreement with the health center specifying their mutual expectations;
• the practitioner will complete an application and sign a release from liability statement; provide contacts for personal references for recommendation letters; if board-certified, provide the name and address of the board so that the center
can obtain verification of certification; provide evidence of current licensure (note: ARNPs should have both an RN license and an ARNP license); provide the name and address of the malpractice insurance carrier that can substantiate coverage exclusions and allegations, settlements, and outcomes for all malpractice claims; and
  - the center conducts a criminal conviction background check on all applicants with the state, regardless of their licensure status.

3. An ambulatory care organization utilizes a credentials verification organization (CVO). The organization adheres to certain principles (for example, primary source verification) in gathering information about individuals who by law and by the organization’s bylaws are permitted to provide care or treatment
  - without direction or supervision;
  - within the scope of the individual’s license; and
  - in accordance with the individual’s credentials. Ambulatory care organizations may, for example,
    - transfer credentials information from another accredited health care organization, a county medical society providing such services, or a freestanding CVO if it documents how it assessed that information and made recommendations for awarding specific privileges; and
    - apply its general credentialing process to determine that the privileges granted are program, category, or site specific.

4. All LIPs must have primary source-verified information regarding licensure, appropriate training, and background experience. The organization may use information provided by a CVO, as long as the CVO meets the nine principles that guide the evaluation of such organizations as identified in the January/February 1998 Perspectives. For example, an organization may utilize the information provided by the American Medical Association (AMA) Physician Masterfile to verify primary source information such as medical school graduation and residency completion as long as the organization additionally checks with the state licensing board to verify current license. The American Osteopathic Association’s Physician Database is also recognized as an equivalent source for Predoctoral Education accredited by the AOA Bureau of Professional Education, Predoctoral Education accredited by the AOA Bureau of Professional Education, and Osteopathic Specialty Board Certification.

5. Each individual who is an LIP completes an application process and is appointed to the staff of the organization after formal approval of the application, which includes verification of the applicant’s education, training, and licensure with the primary source. For example, a physician’s education is verified by writing the applicant’s medical school and asking for corroboration that the individual did attend and graduate with the degree and on the date indicated.

Primary source verification for LIPs may be done by using a form letter that is individualized with the LIP’s specific information and that provides space for the primary source to indicate that the information is correct. The form letter must be signed.

Peer references are obtained by asking for references from the LIP as part of the application process. Each of these references receives a copy of a release form that has been signed by the LIP, along with a letter requesting information about the LIP’s clinical performance, relationships with peers, and ability to relate to patients, as well as an assessment of the LIP’s specialty skills, if appropriate.

When the completed application, primary source verifications, and peer references are available, this information is used to determine if appointment to the staff will improve the operation of the organization and patient care by the designated medical staff representative or credentialing committee. After this analysis, the recommendation for
appointment and granting of privileges is forwarded to the designated administrative staff and presented to the leaders for final action.

6. Newly appointed LIPs are supervised by other members of the staff for a specific period of time. For example, all charts completed by a nurse practitioner are reviewed for a period of two weeks, after which time the extent and frequency of review are decreased. A newly appointed surgeon has a second surgeon scrub on a procedure.

7. Policies reflect the frequency of reappointment to the staff for all LIPs. Reappointment may be done in the same month every two years or be staggered based on the date of initial appointment to the staff. Applicants for reappointment complete a reappointment application and indicate any requested changes in clinical privileges as well as any changes in their status that may affect patient care (for example, changes in hospital privileges at referral sites or changes in their practice due to health). The reappointment process uses performance improvement program findings, peer review findings, morbidity and mortality data, and other data to assess competency before recommending and approving reappointment to the staff.

8. LIPs acknowledge receipt of the organization’s bylaws and agree to obey the bylaws. The bylaws indicate that LIPs are required to notify the facility if they lose staff privileges at an area hospital, are involved in a malpractice suit, have health conditions that would affect their performance, and so forth.

9. The organization maintains a credentialing and privileging file on all LIPs with the exception of non-contracted off-site physicians to whom the organization refers patients.

For HR.7.1 only

10. An ambulatory care organization has a relationship with a teaching hospital to provide residents, medical students, fellows, and volunteer physicians to administer services. The organization receives and verifies the credentialing documentation provided by the teaching hospital and keeps a file for each resident, medical student, and volunteer.

Examples of Evidence of Performance for HR.7 and HR.7.1

- Organization policies and procedures
- Description of licensure, certificates, privileges, and the credentialing verification process

Scoring for HR.7

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>NA</th>
</tr>
</thead>
</table>

a. Is a well-defined process used for appointment and reappointment of licensed independent practitioners?

b. In a Medicare-Certified ASC, do qualified individuals other than LIPs administer anesthesia?

**Score 1**
- a. Yes
- b. Yes

**Score 3**
a. Not consistently

**Score 5**
- a. No
- b. No
Scoring for HR.7.1

1 2 3 4 5 NA

a. What percentage of applicants are appointed or reappointed according to the credentialing criteria outlined in the intent?
b. In a Medicare-Certified ASC, are members of the medical staff legally and professionally qualified for the positions to which they are appointed?
c. In a Medicare-Certified ASC, are members of the medical staff legally and professionally qualified for the performance of privileges granted?

Score 1
a. 100%
b and c. Yes

Score 2
a. 95% to 99%

Score 3
a. 90% to 94%

Score 4
a. 80% to 89%

Score 5
a. Fewer than 80%
b and c. No

Standard HR.7.2
Each licensed independent practitioner provides care under the auspices of the organization in accordance with delineated clinical privileges.

Standard HR.7.2.1
Clinical privileges are granted based on the practitioner’s qualifications and the care provided by the organization.

Standard HR.7.2.2
Clinical privileges are reviewed or revised every two years.

Intent of HR.7.2 through HR.7.2.2
Regardless of the mechanisms used to grant, renew, or revise clinical privileges, the privileges granted must be specific to the organization—that is, based not only on the applicant’s qualifications, but also on a consideration of the procedures and types of care that can be performed or provided within a specific setting. In addition, state law and regulation are adhered to when granting clinical privileges to practitioners other than physicians (for example, physician assistants and nurse practitioners). If an applicant’s training or experience is in a specific area(s), corresponding privileges can be granted only if the organization has adequate facilities, equipment, number and types of qualified support personnel, and any necessary support services. When services of a specialist, such as a radiologist, are contracted, the specialist should be granted organization-specific privileges.

Initial granting, renewal, or revision of clinical privileges must also be based on the individual’s demonstrated current competence. This may be determined, in part, by a review of relevant results of performance improvement activities. Specific instances of treatment outcomes and the results of other improvement activities may also be included. An evaluation of the applicant’s clinical judgment, technical skills in performing procedures and in patient treatment, and management are included in evaluations of current competence. Clinical privileges granted by the organization are reappraised at least every two years.
The clinical qualifications of the licensed independent practitioner are relevant to his or her responsibilities with the organization. A supervised clinical practitioner (for example, nurse practitioner, physician’s assistant) may have a job description rather than delineated clinical privileges, but he or she must have one or the other.

Examples of Implementation for HR.7.2

1. Each LIP is granted specific privileges to practice in the organization. These privileges are based on
   - verification of skills determined by the application and appointment process; and
   - the capabilities and mission of the organization. Privileges are granted for procedures and practices that are part of the organization’s mission and capabilities.

   For example, in a birthing center, the referral obstetrician has privileges for routine deliveries only at the hospital, not in the birthing center. If an organization does not provide chemotherapy, it does not grant privileges to an oncologist to administer chemotherapeutic agents.

2. Privileges may be curtailed whenever a practitioner is unable to provide satisfactorily the types of care covered by privileges. When privileges are curtailed, those who schedule surgery or assist with procedures are informed of the change involving the practitioner’s activities.

3. New privileges can be added at any time, as long as the following procedure is observed:
   (a) The practitioner requests the new privileges and submits evidence of sufficient training and competency, and (b) the medical director evaluates the request and, based on the organization’s bylaws, completes the privileging process and submits it to the leaders for final approval.

   For example, a practitioner requested privileges to perform dermatological laser surgery with an argon laser after attending an educational program on the procedure. The organization expanded the practitioner’s privileges accordingly after it ensured that the practitioner had been trained adequately and was competent; the facility was equipped to provide the service, and support staff could be trained in the operation of the equipment, management of patients before and after treatment, and safe use of the technology.

4. LIPs, such as some nurse practitioners, may be treated as employees of the organization. As such these practitioners do not need to undergo credentialing or privileging procedures. They do, however, have specific job descriptions and undergo the employee evaluation process to show competency.

5. The organization maintains a file containing primary source documents (collected only once as required for initial credentialing purposes), application for appointment and reappointment, privileges granted, peer review and quality findings, and so forth, on each LIP. CME and peer review reports are consolidated into a concise document, which is filed in another location and discarded in accordance with organization policy.

Example of Implementation for HR.7.2.2
Privileges are reviewed and revised every two years.

Examples of Evidence of Performance for HR.7.2 through HR.7.2.2

- Credentials files
- Description of licensure, certificates, privileges, and the credentialing verification process
Scoring for HR.7.2

1 2 3 4 5 NA

a. What percentage of credentials files indicate that clinical privileges are delineated, as described in the intent?
b. In a Medicare-Certified ASC, have physicians performing surgery in the ASC been granted clinical privileges to do so by the ASC governing body?
c. In a Medicare-Certified ASC, are anesthetics administered by a qualified anesthesiologist or a qualified physician?

Score 1
a. 91% to 100% of those reviewed
b and c. Yes

Score 2 a. 76% to 90% of those reviewed
Score 3 a. 51% to 75% of those reviewed
Score 4 a. 26% to 50% of those reviewed

Score 5
a. Fewer than 26% of those reviewed
b and c. No

Scoring for HR.7.2.1

1 2 3 4 5 NA

Is granting of clinical privileges organization specific, as described in the intent?

Score 1 Yes
Score 2 Yes, with the occasional exception of a consultant or contract practitioner in a support service
Score 3 Yes, with the exception of some practitioners
Score 4 Rarely
Score 5 No

Scoring for HR.7.2.2

1 2 3 4 5 NA

a. What percentage of credentials files indicate that licensed independent practitioners’ clinical privileges are reviewed or revised at least every two years according to the criteria described in the intent?
b. In a Medicare-Certified ASC, are medical staff privileges periodically reappraised by the ASC?

Score 1
a. 91% to 100% of those reviewed
b. Yes
Standard HR.7.3
Procedures are defined for discontinuing appointments and curtailing clinical privileges of licensed independent practitioners.

Standard HR.7.3.1
Appeals on decisions to discontinue appointment or deny clinical privileges are considered.

Intent of HR.7.3 and HR.7.3.1
When reports (for example, from a credentialing committee) indicate an adverse decision on an application for reappointment or an action to discontinue clinical privileges, practitioners are afforded an opportunity for a fair hearing and appellate review in accordance with the provisions outlined in the appointment delineation criteria. Appeals on adverse reappointment decisions are given a fair hearing in accordance with applicable statutes. The formal appointment process specifies procedures for handling appeals and includes

- a mechanism for scheduling hearings;
- the procedures to be followed at hearings;
- the composition of the hearing panel; and
- the agenda for the hearing.

Example of Implementation for HR.7.3 and HR.7.3.1
Privileges for a practitioner who, after investigation, was found to abuse alcohol were revoked until he underwent therapy and became a recovering alcoholic. Although the practitioner exercised his rights to the appeal process, testimony from colleagues, surgical nursing personnel, and two former patients who had canceled surgery when they smelled alcohol in the surgeon’s office, confirmed the board’s decision to curtail his privileges and suspend his appointment to the surgery center’s staff.

Examples of Evidence of Performance for HR.7.3 and HR.7.3.1
- Organization policies and procedures
- Description of licensure, certificates, privileges, and the credentialing verification process

Scoring for HR.7.3

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>No</td>
</tr>
</tbody>
</table>

Have leaders approved a mechanism for discontinuing appointment of licensed independent practitioners?

Score 1 Yes
Score 5 No

Scoring for HR.7.3.1
Are practitioners given the opportunity for a fair hearing and appellate review when adverse decisions are rendered about reappointment or renewal of clinical privileges?

Score 1 Yes
Score 3 One applicant was not
Score 4 Not usually
Score 5 No

Aggregation Summary

Enter grid element score

Enter the worst score after applying all the caps.

This is the score for the Credentialing and Privileging of Licensed Independent Practitioners grid element.

Examples of Implementation for Ambulatory Surgery Centers

Following is a list of activities carried out by the staff of ambulatory surgery centers in an effort to provide the best surgical patient care possible.