Medical Credentialing
&
Provider Enrollment Simplified

A Lexicon of Terms and Circumstances

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The Medical Credentialing and Provider Enrollment worlds are complicated, with time-consuming processes and numerous areas of concern…

For a professional entering the industry new, it can be overwhelming. The following is an educational lexicon, packed full of definitions and best practices for the junior Medical Staff Services, Credentialing, or Enrollment Professional.

Look no further for comprehensive information pertinent to Medical Credentialing and Provider Enrollment. This lexicon addresses the following, and ***much more****:*

- *Why Medical Staff Services, Credentialing and Provider Enrollment professionals do what they do!*
- *A fly-by tutorial on the structure of an average Medical Staff*
- *Credentialing and Enrollment best practices*
- *The components of efficient physician onboarding*
- *The varied responsibilities of a Medical Staff Office, including credentialing, privileging, and maintenance of both Rules and Regulations and Bylaws*
- *The differing perspectives and stakeholders in both credentialing and provider enrollment*
- *Clear definitions to help new professionals understand the many complicated situations seen within the industry on a daily basis.*

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Medical Credentialing

***The Joint Commission** describes **medical credentialing** as "the process of obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization. Credentials are documented evidence of licensure, education, training, experience, or other qualifications."*

The definition for medical credentialing is succinct. However, the practice of credentialing calls to force intuition and strong experiential knowledge from professionals. While The Joint Commission's definition is easy to understand, it implies that medical credentialing is predictable. Anyone who's worked in the industry and length of time knows – it's not at all predictable.

First and foremost, it must be understood why the field of medical credentialing exists:

- *Chiefly, to protect patient safety. One only need read "Blind Eye" by James B. Stewart to gain a clear picture of why medical credentialing standards are so important. Between 1981 and 1997, Dr. Michael Swango (AKA "Dr. Death") is believed to have fatally poisoned up to 60 patients and colleagues. Though suspicion after suspicion was raised about this physician, he never failed to gain the privileges necessary to see patients for those 16 years (Read about it Here).*
- *Secondly, facilities have a duty to protect patients and the organization from **negligent credentialing** situations and law suits. A negligent credentialing suit often comes up when a malpractice event either fails in court, or where egregious ignorance or failure in credentialing processes lead to evidence that a physician was granted privileges for which they have no demonstrable experience or competence. Frigo v. Silver Cross Hospital is an $8 Million example. Read about it here.*
- *Lastly, all effort must be made to ensure that physicians are who they say they are, and are qualified to practice. Take in point the 2016 case of an 18 year old who managed to pass himself off as a doctor in Florida for at least a year. Read about it here.*

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Components of Credentialing

Depending on the environment and accrediting body (i.e., The Joint Commission, NCQA, URAC), or even whether a facility is accredited, it can be confusing understanding what components of credentialing are required. As a best practice, you should consider examining all of the following 12 components.

(1) Primary Source Verification. *No, primary source verification is not an item you can check. However, it is the foundation of solid credentialing work. In order to be primary source verified, credentials must be obtained from the originating body of the credential (i.e., educational facility, licensing body, the DEA).*

(2) The National Practitioner Databank (NPDB). *The NPDB should be referenced with any new physician or any status change or renewal. The NPDB will track all "reportable events" (discussed later), and will be an asset in determining any derogatory discretions.*

(3) State Application. *Each state has its own laws and regulations regarding how physicians in that state should apply to medical staffs. Check with your state department of regulatory agencies to determine if you're compliant or whether your process might be due for an overhaul.*

(4) Licensure and DEA. *Keep a close eye on both. Accredited organizations will need to ensure that they secure documentation of both prior to expiration and at every reappointment or status change.*

(5) Verification of Education. *Verification of medical school, residency and any fellowship activity are crucial. This information is needed to determine whether a physician meets the basic criteria to even apply for privileges. Furthermore, information must be gleaned as to whether there were any adverse actions even dating back to medical school, if attainable.*

(6)Demonstrated Competency. *A new provider will need to provide clinical activity reports and (if possible) evidence of competence at the time of initial appointment and each reappointment. Most medical staffs will make some allowances for physicians just exiting residency. For example, they may not have to meet threshold criteria for procedures, but might have to submit a resident log.*

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(7) Board Certification. *Keep a close eye on certifications and whether those who participate in Maintenance of Certification (MOC) are indeed participating. It is not uncommon for Medical Staffs to require board certification with no exceptions.*

(8) Background Checking. *Don't fail to check on a physician's background. Assumption of a clean record can land an organization in court should problems later arise. Also, be sure to use a service which does thorough state and county searches – sometimes convictions can fall through the cracks.*

(9) Application Fee. *It may seem trivial to bring the application fee into importance, but consider this: it is completely common for files to stall ¾ of the way through the process – leaving you out many hours of work. Get the application fee up front, and don't reimburse it unless you've truly not invested the time the fee is worth.*

(10) Peer References. *There's nothing inherently hard about the peer reference gathering process. However, consider whether peer references are appropriate. Make certain they are true peers (i.e., a physician cannot use a nurse practitioner (NP) or physician assistant (PA) as a peer reference, but the NP or PA can use a physician). Also, it's best to use references familiar with the physician's work in the last 1 to 2 years.*

(11) Malpractice Coverage. *Not only is it important to determine whether the physician has past or pending claims against him/her, it's important to be sure they're appropriately covered according to the facility bylaws.*

(12) Addendum Materials. *Most facilities have documentation needing signatures from a new physician outside of their state application. For example, it's common to have a physician code of conduct, or a privacy and confidentiality statement specific to the medical staff. These items should be delivered with the state application.*

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Allied Health Credentialing

Allied Health Professionals: *Advanced Practice Registered Nurses (APRNs, also called Nurse Practitioners); Physician Assistants (PAs); Nurse Midwives (CNMs); Certified Registered Nurse Anesthetists (CRNAs); Registered Nurse First Assists (RNFAs); Depending on the facility bylaws and state law, Nurse Practitioners, Nurse Midwives and CRNAs may be considered and privileged as wholly independent.*

Practitioners like estheticians, audiologists and acupuncturists are not typically credentialed as part of the Medical Staff or Allied Health Staff. More often, they are vetted by Human Resources and have a contractual agreement for physician supervision.

Allied Health and the Medical Staff: *The Centers for Medicare and Medicaid Services (CMS) don't dictate precisely which providers are credentialed as direct members of the Medical Staff. However, it is very common that Allied Health Professionals are not members of the Medical Staff at all, but are credentialed and privileged in the same manner. Generally, all credentialing standards applied to physicians are applied to Allied Health Professionals.*

Credentialing Differences: *There are a few relatively obvious areas where credentialing for an Allied Health Professional is going to differ from their physician counterparts. Allied Health Professionals attain different schooling and work with different individuals than do physicians. Verifying education may be more difficult. For Nurse Practitioners, Edufacts reports will be needed rather than AMA reports (AMA maintains reports on physicians and physician assistants, but not nurse practitioners). Of note: Allied Health Professionals cannot use Registered Nurses as peer references. It may be tempting for them to list their RN coworkers, so watch applications closely for signs that a listed individual is not, in fact, a peer.*

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"Red Flags"

If you've worked as a credentialing specialist, you probably know the feeling: You're working a file, and something just doesn't feel right about the applicant. Sometimes we have a simple gut feeling that there's something more to the picture. Follow your instincts – they're very often right.

Most facilities do have an established list of "red flags" to watch for in the credentialing process. These are items which may simply call for more attention paid in the review process, or could push an applicant out of "clean file" territory. The potential ramification of this is more time spent in committee making determinations as to the appropriateness of the applicant. Here are some red flags to watch for:

- ***Time Gaps.*** *Anything more than 90 days is in need of review; it's not uncommon for facilities to require gap explanations for periods as little as 30 days, though.*
- ***Medical School / Residency / Fellowship Hopping.*** *If your physician attended more than one medical school, residency program or fellowship program, attention is needed. If the physician finished a program and moved on to another specialty, further examination is not required, but unfinished programs are suspicious.*
- ***Complicated Work History.*** *Affiliations aren't really the concern, here – physicians can be affiliated with many locations before things look strange. Work history is another story, though, as this often involves employment contracts and relocations. If a physician has worked in more than five locations that meet these criteria in the last ten years, make certain to glean as much quality information as possible from previous employers.*
- ***Large Malpractice Settlements or Judgments.*** *In general, malpractice history should be reviewed thoroughly.*

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- ***Poor Peer References:*** *I've had this happen to me – A physician is pleasant and kind in person, easy to work with. The file is coming along nicely, then right at the eleventh hour that last peer reference comes in. It's a bomb, full of implications that this physician has some problems. Alert reviewers immediately so that calls can be made to the peer reference in order to clarify their reference form.*

- ***Adverse Facility References.*** *When sending out affiliation verifications and obtaining work history verifications, forms sometimes come back with derogatory information. As with peer references, alert committee reviewers as soon as possible.*

- ***Any Disclosure of Convictions or Treatment for Substance Abuse.*** *Sometimes these situations don't come to light until a peer mentions it. Sometimes, the applicant is very cooperative and forthcoming. Either way, work with the committee as early as possible to open the lines of communication with the applicant and determine whether patient safety is a concern.*

- ***Too Many State Licenses.*** *Primarily, a large number of licenses where affiliations do not correspond could indicate an incomplete application needing further information. On the flip side of the coin, it can be helpful to look at AMA reports or other information repositories to determine whether any state licenses were left off the application. If so, check to be sure there are no adverse actions in the omitted states and contact the applicant to clarify work history and affiliations.*

As with most situations, don't assume that red flags immediately disqualify candidates, and view every file with objectivity. When possible, coordinate with the Credentials Committee and your director to avoid conflict and vet a candidate appropriately.

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Disclosure of Disciplinary/Adverse Action or Legal Action: *Sometimes, watching for red flags, you'll encounter evidence that an applicant has not disclosed an adverse action taken against them by an employer, facility, educational program, licensing board, etc. Tread carefully in this circumstance and keep your superiors involved. The applicant is in a vulnerable position, as they've likely omitted these actions from their state application and on any pre-application your facility used to determine their appropriateness for staff membership. It may be prudent to involve your facility's legal team sooner rather than later.*

Pre-Applications: *Depending on the facility, pre-applications may be used as a means to control who is granted the right to submit an official application to the medical staff. During the pre-application process, the applicant may be considered on the basis of their specialty, their declared attestations, their licensure and DEA status, their call coverage plan, and other criteria. Before implementing a pre-application, view it as a contract and have it checked over by your legal team. While the pre-application can save headaches by allowing for additional selectivity, there are many ways in which it can backfire if not handled appropriately.*

Council for Affordable Quality Healthcare (CAQH): *CAQH is a non-profit organization used as a network of access for physicians and insurance companies. CAQH Proview is the cloud-based software application used to warehouse vital physician information for access by payers. CAQH Proview is also capable of integrating this vital information into appropriate state applications.*

Visit https://proview.caqh.org/ for more information.

E-Signatures: *The decision to accept electronic signatures is ultimately left to the facility. However, there should be some effort taken to ensure signatures are valid – be sure signatures are validated with a timestamp or individual ID.*

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Reappointment / Re-Credentialing

Initial credentialing is a big part of the battle, but it is the reappointments that will ultimately keep a credentialing specialist busy. There are two big concerns, here: the reappointment schedule, and the information collected.

Reappointment Schedule: *Depending on the presence of an accrediting body, reappointment schedules can vary. The Joint Commission requires that physicians be reappointed no less than once every 24 months, to the day. NCQA requires physicians be reappointed every 36 months, and allows for an end of month reappointment date as a very slight grace period. Facilities may also reappoint based on initial appointment date, birth date, social security number, specialty, etc. Really, any way can potentially work, but consider how those groupings will contribute to your ability to get files to committee on time. Bottom line: Make sure your facility is operating within the requirements of its accrediting body.*

What Comprises a Reappointment File? *In most instances, facilities choose to check the majority, but not all, of the items reviewed during the initial appointment process. Most often, standards dictate or facilities decide to review:*

- *National Practitioner Databank*
- *Malpractice Insurance and Claims History*
- *Licensure and DEA*
- *OIG/SAM searches*
- *Peer References*
- *Active or New Affiliations*
- *Board Certification*
- *Continuing Medical Education*
- *Demonstrated Competency*

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***Confidentiality of Physician Info:** We all know we need to protect patient information. In the need to protect our patients, we sometimes forget that we need to also protect our physicians' information. Be sure to write a clear policy outlining under which circumstances and with whom protected physician information may be shared. Also, accrediting bodies tend to require that physician information is stored under lock and key. Be sure to check the regulatory requirements of your accrediting body and ensure you're in compliance.*

***Locum Tenens Credentialing:** In many ways, Locum Tenens physicians are a whole different ball game in the credentialing and enrollment arenas. Remember, it's important to understand motives behind hiring Locum Tenens in order to ascertain how best to credential them according to your facility's Bylaws. More information on the enrollment and billing importance related to Locum Tenens will come later. For now, know that Locum Tenens are often among the most difficult to credential. More often than not, their files come with one or more red flag (most often because Locum Tenens tend to work at a high number of facilities in a number of states). Typically, more verification will be done on a Locum Tenens provider, and often with organizations and physicians in varied locations. Be sure to consider the timeframe on a Locum Tenens provider realistically while in discussions with practice managers or other stakeholders.*

***Denials:** In credentialing, be wary of denials. In Human Resources, it's simple to tell a candidate they've simply not been chosen to continue after review of their application. No harm, no foul. It isn't so in physician credentialing. Denials of physicians must be well-documented and for clear reasons which relate to patient safety or other major concerns. Denials are reportable to the National Practitioner Databank, and therefore must be considered carefully. Denials can leave a facility vulnerable to lawsuit by the physician in question. Rule of thumb: never tell a physician their file has been denied. This should be left to the Chief of Staff or Director of Medical Staff Services, and only after advice from an attorney. More often, unsuitable candidates will instead be asked to withdraw their applications. They will typically comply, as they don't want to be reported to the NPDB any more than facilities would like to report them.*

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Medical Staff Services

Medical Staff Services/Medical Staff Office: *Sometimes, it'll be referred to as Physician Services or a derivative term. No matter what it's called, most hospitals will have a department devoted to its medical staff, tasked with credentialing physicians, administering the Continuing Medical Education program, acting as an administrative staff for the Chief of Staff and committees, conducting Ongoing Professional Practice Evaluations, and as general advocates for physicians. The list goes on and on as to what the Medical Staff Office may handle for the medical staff.*

Structure: *It is important to note that the Medical Staff Office compliments and serves the medical staff of a hospital. While the director and employees within the office help to clarify and enforce the rules and regulations and bylaws of the organization, they do not control the medical staff. The medical staff is independent and most often self-governing, and operates separate of hospital administration, which will usually have its own set of rules and regulations and bylaws dictated by the Board of Trustees. In the Medical Staff Office, you'll often see the following staff:*

- ***Medical Staff Specialist/Coordinator:*** *This individual may or may not credential physicians, but will certainly serve them administratively. They may help with committee meetings, administer the CME program, help with bylaws/rules and regulations, assist the chief of staff, etc.*
- ***Credentialing Specialist/Coordinator:*** *This individual is more singularly dedicated to the credentialing and privileging duties within the office. They will work physician files, sometimes "pitch" them to committees, perhaps assist with committee meetings, keep in touch with credentialing physicians, etc.*
- ***Medical Staff Services Director:*** *There may be a manager intermediary between specialists/coordinators and the director – there may not be. Either way, the director of this department most likely conducts and maintains minutes for committee meetings, works with the Chief of Staff to resolve internal issues, including disciplinary, liaises with other departments, and handles upper-level requirements of his/her own department.*

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***The Medical Staff:** Since the medical staff is typically self-governed, there must be appropriate structure allowing for an efficient self-governing body. Here are some of those structures to keep in mind:*

- ***Chief of Staff:** Also called the President of the Medical Staff, this physician is elected into his/her position by members of the medical staff with voting rights (more about that later). The Chief of Staff works closely with the Medical Staff Office and the Credentialing Committee to ensure the competence of physicians onboarding. Generally, the Chief of Staff has the final say as far as the Medical Staff Office is concerned. The Chief of Staff will also be directly involved in implementing quality initiatives within the facility, resolving disputes and disciplinary problems, addressing competency issues, enforcing the rules and regulations and bylaws of the medical staff.*
- ***Committees:** Commonly, the medical staff will have multiple committees performing the maintenance duties necessary for their self-governing system. Commonly, committees will include the Medical Executive Committee (this is the highest level committee – charged with maintaining safety and quality, and chaired by the Chief of Staff), Credentialing, Governance (bylaws/rules and regulations), Care Evaluation or Peer Review, Infection Control, Tumor Board, Utilization Review, etc. Really, the sky's the limit where committees are concerned, but they must adhere to rules set out by the bylaws. New committees must be written into the bylaws in order to be considered a medical staff committee. Their chairmen can be elected officials or candidates hand-picked by the Chief of Staff, again dependent on the bylaws.*
- ***Departments:** Medical staff departments can be confusing. It can seem like a practice should be a department, but it's not (rather, it's a service line - stay tuned for more on service lines). Typically, a hospital will have two medical staff departments: the Department of Medicine, and the Department of Surgery. Each of those departments has a chief: the Chief of Medicine and the Chief of Surgery. Those positions can be powerful or largely decorative, depending on the medical staff bylaws. At the very least, department chiefs are usually responsible for signing off on new medical staff candidates within their department and ensuring that any proctoring is appropriately received. They are often part of the Medical Executive Committee, and will work to improve safety and quality in their respective departments.*

- ***Service Lines:*** *As mentioned, what we might consider a department in any other business is really a service line in a hospital environment. This is the entirety of services rendered for any given specialty. For example, a birthplace, OB-GYN's, Midwives, Neonatal physicians and Nurse Practitioners, and Pediatricians may all be considered relevant to a single service line. Service lines may or may not have chiefs or heads, and may or may not participate in service line meetings. It's important to understand service lines, particularly for privileging and new procedures. It must be clear who is responsible for each aspect of a new procedure, a new piece of equipment, or a new or standing physician needing proctoring.*
- ***Allied Health / Advanced Practice Professionals:*** *Most often, this category will include Physician Assistants, Nurse Practitioners, Certified Registered Nurse Anesthetists, and Midwives. Depending on state regulations and hospital bylaws, Nurse Practitioners, CRNA's and Midwives may all be considered independent practitioners, or may need a supervising physician. The hospital has the right to act more stringently than the state – therefore, no Allied Health Professional is entitled to more freedom to practice than the hospital is willing to give! Physician Assistants may never, under any circumstances, be considered independent practitioners. CMS and the hospital will have according supervision levels and criteria for practice in general, and for special procedures. These will often differ in structure from physician privileges, but supervised Allied Health Professionals may never have privileges which the supervising physician does not hold. Be sure to compare physician and Allied Health Privileges side by side carefully.*

  Allied Health Professionals are typically not part of the medical staff. They are still credentialed and privileged in the same way, but may be a member of a separate staff category. While CMS does not dictate that Allied Health Professionals cannot be medical staff members, membership is often reserved for Medical Doctors and Doctors of Osteopathy.
- ***Voting Rights:*** *As hinted at earlier, not every medical staff member will have voting rights. Allied Health Professionals will likely have no voting rights, and staff members which are part of provisional, courtesy, or associate categories, Locum Tenens or any member outside of the active staff may be non-voting. Consult your bylaws for the final word.*

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Bylaws / Rules & Regulations

Bylaws: *You'll hear the bylaws referred to time and time again, and that's because the bylaws are the basic infrastructure upon which the medical staff and the medical staff office are built. The bylaws are built as desired by the hospital and the medical staff, and within the regulations of any accrediting body. Bylaws need to be built with careful consideration – facilities that cannot follow their own bylaws to the letter are in a vulnerable place, legally. The bylaws will dictate how committees are run, procedures for review and revision to bylaws and rules and regulations, disciplinary action and due process, credentialing procedures; essentially, the bylaws will dictate the lines in which you conduct your business with the medical staff. Exceptions will usually require formal approval by the Chief of Staff, the Medical Executive Committee, and the Board of Trustees.*

Rules and Regulations: *What's the difference between the bylaws and the rules and regulations? While the bylaws dictate how the medical staff is structured and governed, the rules and regulations address specific processes and procedures should they arise. For example, the bylaws may require that all physicians take part in the Emergency Department Call Schedule, but the rules and regulations may contain a policy on which forms of communication a physician may declare for call and how many modes of communication must be disclosed at all times. Flu shots and TB testing policies, clinical areas of concern, codes of conduct are all popular rules and regulations as well.*

Continuing Medical Education (CME): *CME is important from the standpoint of privileging and medical staff membership. Typically, physician privileges will contain a requirement stating that X number of CME credits must be completed in his/her privilege in order to qualify for reappointment. There may be a separate requirement for initial appointment. Bottom line: encourage physicians to keep current on their CME, and to send certificates as soon as they are available. Major problems occur when a reappointment is held up or needs special consideration for something as basic as CME credits. Most physicians need these credits to qualify for maintenance of certification with their specialty board – they should, in most cases, have plenty of documentation available.*

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Privileging

What's the difference between "Credentialing" and "Privileging"?

In order to understand why privileging matters, it's important to know why it's different from credentialing. Credentialing is the process of collecting documentation and evidence related to a practitioner's history, qualifications and competence. Privileging is then the process of taking that evidence and using it to justify the procedures the practitioner will be cleared to perform at your facility. That justification is made by the medical staff, but privileging specialists have an important set of niche responsibilities:

- *Creating appropriate privileging documents by keeping to CMS, state and federal laws and guidelines, and by researching regional facilities' privileging documents.*
- *Understanding how board certifications, residencies, fellowships and other experiences and education modalities enhance physician competency – and incorporating that into facility privileging and bylaws.*
- *Understanding the sometimes fine differences between practitioner types, including what's appropriate for Allied Health Professionals.*
- *Creating documents which make sense to physicians and board members (not as easy as it sounds).*
- *Using existing privileging criteria early in the credentialing process in order to ensure competency and appropriateness of applying candidates.*

Temporary or Special Privileges: *Temporary privileges are granted when an urgent need compels the medical staff to approve a physician to work in the facility prior to completion of the formal credentialing and privileging process. This should be rare, as it's a liability to the facility. Also, note that temporary privileges do not supersede the formal process. Rather, those temporary privileges would be enacted only until such a time that the file can be sent for formal review and approval.*

Special privileges are those which fall outside of the category of "core". That is, they may require extra education or experience, certification, etc., in order to be granted. There will also be competencies to demonstrate during each reappointment cycle.

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Staff Category: *The staff category is an extension of basic privileging, and describes the physician's role in the medical staff a little more clearly. For example, most facilities categorize physicians as Active staff, Associate/Affiliate staff, Allied Health, Provisional, Temporary, or any similar division. Medical Staffs are free to govern staff categories, mostly, as they see fit, but there are generally a few commonalities. Active staff members will have voting rights, full rights to stand on committees, to run for staff official positions and committee chairs, and more than likely the medical staff will lay out ground rules as to whether they must have a residence in vicinity of the hospital. As far as other categories, there can be quite a bit of variance. Almost all staffs, however, will have a category describing members who either do not want active membership or do not qualify, but want to be participatory – these members usually have no right to treat, touch, or order procedures for any inpatient inside the facility.*

Staff Status: *Staff status and staff category are easily confused, as their wording is very similar. A member can be an Active Staff member with Active Staff status. Simply put, the staff status describes the practitioner's standing: Active, expired, resigned, on leave of absence, or (in worst case scenarios) suspended, revoked, etc.*

Termination and Resignation: *It's important to understand that "termination", as a term used in staff verifications, is not always a red flag. Neither is a resignation, expiration, etc. Many facilities use singular terminology to simply explain the act of removing oneself from the medical staff, voluntarily or otherwise.*

Disciplinary Measures: *Many facilities will not release quality or disciplinary information when releasing staff verifications. Similarly, disciplinary information may not be available directly from educational facilities. In these instances, it can be helpful to obtain references from chiefs of staff or program directors.*

Medical Staff Code of Conduct: *Typically, the code of conduct for physicians runs parallel to HR conduct policies (particularly for employed physicians). The code of conduct is usually not part of the facility bylaws, but part of the rules and regulations, and will offer specific instructions as to how disruptive behavior is to be managed.*

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New Procedure Policies: *It's tempting to think of new procedures as the problem of RN's, House Supervisors, Directors, etc., and, really, they are. There is, however, culpability in the Medical Staff Office to ensure physicians have adequate proctoring, if needed. There should be a new procedure policy, and physicians needing proctoring should be made aware of it, along with the proctor and the surgical team. If privileges are revised to reflect new procedures, be aware that responsibility doesn't leave the Medical Staff Office the moment the Board of Trustees signs off on the privilege.*

Physician Call Schedule: *Call schedules are messy, and the cause of many a heated argument. There is no right or wrong to conduct call schedules, but be aware of what the facility bylaws have to say about it. Very often, service lines are designated as essential or non-essential, and the ability of Allied Health practitioners to participate in call is often limited. To add another layer of complication, physician agreements regarding call are often written into their contracts. Similarly, make sure these provisions are also understood by the contracting team.*

Physician Onboarding: *Onboarding is expensive, time-consuming, and confusing. The term "onboarding" is broad, and can describe as simple a process as taking a new physician to HR or one as convoluted as can possibly be imagined. Generally, physicians should not be working prior to obtaining a drug test (and this can be tough – Locum Tenens, in particular, can throw a wrench in this!), and without being introduced to parties likely to encounter them. It's a good idea to send out a photo of the physician facility-wide in order to allay any suspicion that they shouldn't be there. Nurses should never have to wonder whether the person in front of them is actually a doctor. Conversely, a physician shouldn't be working without a basic idea of how business is conducted, how to use the electronic health record or ordering system, etc. A thorough onboarding process (without approaching ridiculousness) is in the best interest of the facility and the provider.*

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OPPE/FPPE

OPPE and FPPE are two frequently misunderstood terms (and acronyms!). Let's look at what they mean:

OPPE: *This is the Ongoing Professional Practice Evaluation. The basic purpose of OPPE is to explore quality of physicians' practice patterns, in accordance with each specialty's needs, and with meaningful, reliable data. OPPE is required by The Joint Commission and NCQA, and must be administered in accordance with accreditation standards. Outside of accreditation, though, OPPE is a worthwhile practice, and nicely compliments traditional peer review activities.*

FPPE: *Focused Professional Practice Evaluations work similarly to OPPE's, but are used only when necessary. Primarily, FPPE's target either more specified skill sets/competencies or timeframes. An FPPE may be granted to every new physician at a facility, requiring a specified amount of proctoring by another physician or another form of review. FPPE's may also be used for physicians who either don't meet established facility standards, or whose competencies are in need of monitoring. At reappointment, a physician not meeting the lowest threshold for competency (expressed as a number of procedures adequately performed) may be granted an FPPE in order to retain privileges. A physician experiencing difficulties with a particular procedure may be ordered to undergo an FPPE plan in order to evaluate whether the physician is competent to continue performance of the procedure. FPPE's can also include orders to obtain outside training and referral to a state physician health program. Generally, the ability to retain privileges is contingent on the outcome of the FPPE.*

OPPE and FPPE are very much a part of the credentialing and privileging process. Very often, approval of privileges is contingent upon proof of successful practice by way of OPPE or FPPE. During the credentialing process, obtain OPPE data whenever possible – your Credentials Committee will appreciate it!

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HR vs. MSO

Particularly in a hospital setting, it can be confusing understanding which has more power over physicians: the Human Resources Department or the Medical Staff Office?

Hospital vs. Private Practice or small office: *This is probably pretty obvious, but in smaller practices and offices, control over physicians is an entirely different beast. Whereas hospitals are bound by bylaws, rules and regulations, a practice can be more egalitarian. Physicians will have fairly free reign, as long as they stay in the good graces of their colleagues (this does not apply to hospital and health network-owned practices, though). Human resources will have very little control over physicians' daily actions, but may come into play if another employee's rights are violated or if there's sign of behavior which may violate HR-related policies (i.e., drug abuse).*

So, Human Resources or the Medical Staff Office? *The answer is both. Human resources acts with the best interest of employees in mind. Therefore, in any situation wherein a physician is deemed disruptive to employed staff, HR has the right to be involved. Whether final recourse lies with Human Resources is another matter, though. More than likely, disciplinary measures will be enacted through the Medical Staff Bylaws and code of conduct for physicians – which are enforced by the Medical Executive Committee and the Chief of Staff.*

In the case of employed physicians, the facility has more leverage. An employed physician whose contract is based upon their employment has no leg to stand upon in attempting to retain privileges in spite of termination. A physician who has no employment relationship with the facility is a little more difficult to eject, and leaves the facility open to legal action should it be decided that such a physician must be terminated. In either situation, decisions regarding termination (employed or otherwise) should always be approached with caution, and whenever possible the facility legal team should be involved.

Medical Staff Policies

Medical Staff policies deeply affect how physicians' money, time and education. Three areas of concern often given less attention than needed in the Medical Staff Office: Medical Staff dues, vaccination policies, and certifications.

Medical Staff Dues: *Just like any situation in which a membership is retained, the vast majority of medical staffs require that physicians pay yearly dues. These dues cover the cost of medical staff activities, like weekly continuing medical education or networking sessions. They also cover the cost of the physicians' reappointments. It's imperative that these dues be collected annually in order to maintain adequate funding. Some policies require that physicians be penalized if dues are not paid, up to and including loss of privileges. Adhere to these policies and review them carefully. Granting exceptions should be the decision of physician or administrative leadership only.*

Vaccination Policies: *States actually have differing legislative policies governing healthcare provider vaccination requirements. Review these requirements (if any) to determine whether your facility is operating inside the governing laws of not only the state, but of any accrediting body. Physicians refusing vaccination should be documented and excepted through a formal process (i.e., voucher for religious exemption, medical allergy, etc.). Those refusing to undergo due process for an exemption may then be penalized up to and including suspension of privileges. Most facilities will grant exceptions with the caveat that providers must be masked during patient care.*

Certifications: *Two certifications to watch: Physician board certification, and educational life support certification (ACLS, PALS, NRP, ATLS, etc.). Board certifications are often required for privileges to be granted. Expired boards can mean a loss of privileges! Life support certification may be required for specific specialties or privileges (i.e., sedation or emergency medicine). Again, expiration of these certifications could mean loss of privileges for someone. Create a system by which these certifications are monitored continuously and regularly.*

Provider Enrollment

"Provider Enrollment" is a blanket term, covering the addition of providers to managed care panels, private insurance networks, and federal and state programs (Medicare, Medicaid, Tricare, etc.). The enrollment process can be arduous for some payers, and varies from state to state. Below are some considerations for those easing their way into enrollment.

CMS 855 Forms: *CMS accepts enrollments, changes of address, reassignment of benefits, discontinuation of benefits, and changes of ownership through various 855 forms. For the sake of simplicity, below is a general list of which form to use in which situation (but do keep in mind that there are too numerous a number of scenarios to cover them all here!).*

- ***855B:*** *Enrollment for clinics/group practices, and some suppliers; to enroll in a separate jurisdiction; to make changes to the practice's information.*
- ***855I:*** *The 855I may only be filled out by the practitioner! Use for enrollment as a sole proprietorship; enrollment as an individual to practice in a group setting; Enrollment in a separate jurisdiction; make changes to individual information; for revalidation. Note: Physician Assistants cannot submit a reassignment of benefits; Therefore, all enrollment and discontinuation of benefits is performed via the 855I.*
- ***855R:*** *The 855R is used to reassign benefits only. Complete the application if rights to bill Medicare are being reassigned to another practice or group. Termination of a benefit may also be submitted with the 855R. A separate form must be submitted for each organization which will bill for the practitioner. Note: Physician Assistants and sole owners do not complete the 855R, as all information is reported on the 855I.*
- ***855O:*** *The 8550 is for ordering and referring physicians and non-physician practitioners. Individuals submitting this form wish to order and refer items and/or services to Medicare beneficiaries. This form does not allow for reimbursement of claims.*

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***CAQH:** CAQH is the Council for Affordable Quality Healthcare. It's a non-profit organization which supplies enhancements for credentialing and revenue cycle uses. CAQH Proview interfaces with payers, allowing individual providers to open their information to these payers simultaneously rather than maintaining separate files with each. For credentialing, CAQH is invaluable because it offers an electronic version of each state's universal credentialing application. Generally, providers who have a CAQH ProView account which is up to date will have a simpler time maintaining their credentialing files. A few notes about CAQH:*

- *The file and account belongs solely to the provider. This is important to keep in mind as a facility. It is absolutely normal for a facility to obtain physician CAQH log-ins so the facility may maintain the account on behalf of the physician. However, one facility's desired use for the account should never impede the ability of another legitimate organization to receive payment or otherwise engage with CAQH on the physician's behalf. For example, if the physician has a primary facility and a secondary facility, the secondary facility should not enter into CAQH and mark the primary facility as expired. That facility may stop receiving payments from payers.*
- *If updating an account on behalf of a physician, keep in mind that CAQH sends out quite a number of confirmations and notices. It's important to inform the physician of this, as they're often unaware of their account and may think someone is fraudulently using their information. Let the physician know that you're updating the account and that they'll be receiving notices which they can disregard.*
- *The accuracy of data on CAQH is more important than a lot of people think. It's not a matter of payers just knowing your contact information so your facility gets paid. Most payers use CAQH to populate their physician directories. Outdated information about facility affiliations, whether physicians are taking new patients, plans accepted, etc., can cause an array of frustrations for patients. CAQH will ask that you update the account quarterly. At each update, check the entirety of the physician information to ensure that it is up-to-date and accurate, as this will best serve patient care and physician reputation.*

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E-Signatures: *Just as with credentialing, electronic signatures in payer enrollment can be tricky. CMS does accept electronic signatures for enrollments, but those forms must be submitted through the PECOS system. Once you complete the application in PECOS, you may then send the attestation pages out to the provider for an electronic signature, which will then be populated and returned through PECOS. A word of warning, though: Physicians very often find the process onerous and difficult to decipher. Technological issues can also hamper the ability of physicians to access the signature page. Always be ready to get an ink signature. CMS will accept only wet signatures for initial applications. If there is a signature on file for a physician, developments and other maintenance paperwork may be sent by fax or email with a scanned signature.*

Bottom line: always research facilities and payers prior to sending electronically signed paperwork. Each entity has a different policy. If you are sending something electronically signed, ensure that the signature includes a date stamp and an electronic ID tracing the signature back to the physician's account.

Change of Ownership (CHOW): *On the surface, changes of ownership seem relatively simple, from the perspective of CMS enrollment. An 855I and 855B may be submitted reflecting the change of ownership; while the 855B is lengthy and requires a great deal of information, it's relatively simple to understand. However, it may be best to caution physician owners about the CHOW prior to submission of the 855B. It is the responsibility of the new owner to decide whether to accept the previous owner's participation (PAR) agreement. If the owner does not accept the existing agreement, the change of ownership is considered a new enrollment and a site visit is scheduled. A word of caution: do not assume that the existing PAR agreement is the best deal available to the practice. If the previous physician was restricted in any way or had other issues with CMS, the PAR agreement may reflect a reduction in reimbursement. It is crucial that the PAR agreement be examined for such signs. While waiting for a site visit and final verifications is time and money consumptive, it will not be nearly as expensive as accepting a restricted PAR agreement for the life of the practice.*

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"Deemed" Credentialing: *This term can be confusing, and sometimes even the payers themselves don't understand the concept of "deemed" credentialed providers. "Deemed" credentialing is just as it sounds: these providers are considered already credentialed prior to entering into a payer network. The providers must be primarily hospital-based, which allows the payer to accept the hospital's credentialing in lieu of their own credentialing process. Typically, specialties like anesthesiology, radiology, and pathology are deemed credentialed by payers. In these cases, it will be helpful to point this out to the payer, as the technicians may not recognize this and issue full credentialing. Frequent follow up is advised. Physicians who work in private practices will not be deemed credentialed.*

Disclosure of Discipline/Adverse Action/Legal Action: *As in credentialing, failure to disclose disciplinary or adverse actions to payers can be disastrous for physicians. CMS, in particular, has strict regulations regarding disclosure of these actions. Each 855I and 855B will ask that any adverse history be disclosed. Failure to disclose can lead to a ban from the Medicare and/or Medicaid programs. In fact, CMS is working to tighten these regulations, and seeks to gain power to bar physicians for the length of their entire practice in certain cases. Each time an 855I is submitted, this information must be repopulated and attested to with a fresh signature – even in the case of a simple address update.*

Effective Dates and Payment Gaps: *Consideration of start date is crucial to avoid gaps in payment. Check each private payer to see how early an application may be submitted for a physician. Getting an early start can ensure that the physician is able to engage with as many patients as possible, and begin earning income for the practice as early as possible. CMS accepts applications to the Medicare and Medicaid programs as early as 60 days prior to the first scheduled patient. Because Medicare and Medicaid contractors can run severely behind, it's advisable to get these applications in 60 days prior if at all possible. However, in the event that it isn't possible, CMS will retroactively approve applications up to 30 days prior to the date of receipt.*

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Completeness of Applications: *A key to successful enrollment is the completeness of the applications sent to payers. Applications lacking information or having obvious discrepancies will be undoubtedly delayed. In the case of some payers, it may take up to 30 days to notify the enrollment specialist of missing information or discrepancies. Take the time to review applications and letters of intent prior to forwarding them to payers – it can make all the difference in the long run.*

Developments: *CMS contractors will issue developments in order to request missing information for applications, address updates, reassignments of benefits, etc. Keep an eye out for these – failure to return the requested information within the stated timeframe can result in suspension of payment. At the very least, failure to notice a development can be time consuming. Development requests with no follow up response are often met with an application denial, which will require a completely new application and new signatures from the physician. Needless to say, this is not time well spent.*

Private payers will also issue requests for additional information or correction to an application. Keep a close eye on your email for these. They are often encrypted, and the timeline for turnaround on these requests are much tighter than CMS'. It's not unusual for a private payer to give a 24 hour turnaround time on the request before closing the file altogether. Again, this means the application and its timeline starts over.

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Whether you're new to medical credentialing, privileging or provider enrollment or an expert, new circumstances and regulatory changes can make the industry not only dynamic and exciting, but also challenging and confusing. The foundational knowledge provided here can help new professionals to gain an understanding of some common circumstances in daily function. However, no white paper can prepare a staff member for the diverse possibilities in Medical Staff Offices, Central Verification Offices, or even private practices.

Paramount Professional Services understands the needs of providers and facilities, and our staff of experienced professionals is available to help in any way possible. If you still have questions, or your challenge wasn't addressed here, give us a call or send an email today. We can't wait to help you!

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