Credentialing Policy and Procedure Manual

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Status: Active
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SCOPE: Medical Staff

POLICY:

It is the policy of Virginia Mason Memorial (VMM) to provide applications for appointment or reappointment/credentialing or recredentialing to the Medical Staff and/or clinical privileges to all eligible applicants in categories recommended by the Medical Executive Committee and approved by the Hospital Governing Board.

I. Medical Doctors, Osteopathic Doctors, Podiatrists, Dentists, and Allied Health Professionals (AHP) requesting initial appointment/or initial credentialing will be provided a Request for Application form that outlines the mandatory requirements for the department requested.

AHP Categories include but not limited to Advanced Registered Nurse Practitioners (Certified Nurse Midwives, Certified Registered Nurse Anesthetists, and Neonatal Nurse Practitioners), Physician Assistants, Psychologists, and Registered Nurse-First Assistants.

II. All applicants meeting the basic requirements will be reviewed for appropriateness and professional competence in accordance with the procedures outlined below. It shall be the Applicant’s responsibility to provide acceptable evidence that application requirements have been fulfilled.

Credentialing defined: The process of obtaining, verifying and assessing the qualifications of Applicants who are licensed, certified or registered to practice at VMM.

III. Credentialing decisions- In its decisions regarding appointment and privileges, or credentialing, re-credentialing, VMM does not discriminate on the basis of an applicant’s race, ethnic/nation identity, religion, creed, gender, age, sexual orientation, disability, veteran’s status, procedure or patient type (i.e. Medicaid patients) in which the provider specializes, or any other basis prohibited by State and Federal law.

The criteria used for credentialing is designed to assess a practitioner’s ability to deliver care. No practitioner may deliver care to a patient prior to a decision for approval by the VMM Governing Board, with the exception of Temporary/ Locum Tenens providers which are approved by the CEO on behalf of the Governing Board as note in the Delineation of Clinical Privileges Policy. (See Appendix I-Delineation of Clinical Privilege Policy)
IV. **Reappointment cycle** - In compliance with The Joint Commission, reappointment/re-credentialing shall occur within a 24 month timeline.

V. **Policy review** - This Policy will be reviewed on an annual basis in compliance with delegation agreement requirements.

VI. **Delegation** - VMM is accredited by The Joint Commission. In accordance with the Health Plans criteria for the Delegated Credentialing agreements, effective 4/1/2018, VMM will also meet all relevant National Committee for Quality Assurance standards.

VMM may, from time to time, delegate to another healthcare entity the credentialing and re-credentialing pursuant to a written agreement compliant with The Joint Commission (TJC), National Committee on Quality Assurance (NCQA), and Centers for Medicaid and Medicare Services (CMS) standards associated with the applicable credentials review and privileging processes, and the maintenance of continuous TJC accreditation without findings related to these functions. Such delegation shall require an annual compliance audit performed by, or at the direction of, VMM and a report provided to the delegated entity, along with a requirement for a corrective action plan and its timely execution, if applicable, to the audit findings.

A roster of the practitioners included in the health plan delegated agreements will be sent to the contracted health plans on a monthly basis with practitioner and/or location additions, changes, or terminations with the date of effectiveness for each line item. The Roster information is pulled directly from the credentialing system used to verify and monitor the information used in the credentialing decision. Updates to the practitioner’s information will be gathered and maintained continuously in the credentialing system.

Practitioners who have opted out of Medicare or Medicaid will not be included on the delegation roster for health plan enrollment.

VII. **Rights of the Applicant: Review of the Application Information** - Upon receipt of a completed application from any Applicant, Medical Staff Services will contact the Applicant and acknowledge receipt of the application. Medical Staff Services will inform the Applicant of the estimated time to complete the credentialing process, and provide a statement describing the Applicant’s rights to review the information submitted in support of the credentialing application. All applicants are afforded the following rights with regard to their application and credentialing process:

1. The right to review information obtained by VMM, including information from any outside Primary Source (i.e., malpractice insurance carriers, state licensing boards, National Practitioners Data Bank (NPDB)), that was used to evaluate the credentialing application, with the exception of reference recommendations or other information that is confidential and protected as part of the quality assurance and/or peer review process.

2. If, as a part of the right to review process, the Applicant finds the information obtained during the credentialing process by VMM, that he/she believes to be incorrect, the Applicant will have 10 working days to submit documentation in support of his/her position. Medical Staff Services will acknowledge receipt in writing.
3. Any Practitioner who wants to review his/her credentials file must submit a written request to the Office of Medical Staff Services to arrange a time to meet with either the Manager of Medical Staff Services or a Credentialing Specialist. Request for file review must be received by the Office of Medical Staff Services at least one working day in advance.

4. The right to correct erroneous information: In the event that the credentialing information obtained from other sources varies substantially from that provided by the Applicant, Medical Staff Services will contact the Applicant within 45 days of the receipt of the information. A response from the Applicant will be requested within the time period stated in the request for clarification, or in a documented telephone conversation. The practitioner is responsible for correcting or clarifying any discrepancies prior to his/her application being forwarded to the Credentialing Committee for review. The background check will verify criminal history record. If adverse information is obtained, the applicant will be contacted, requesting further details regarding the report.

5. The right to receive the status of their credentialing or re-credentialing application upon request

6. The right to receive the notification of these rights.

VIII. **Confidentiality:** Information obtained through the credentialing and re-credentialing process is considered confidential and protected information

Credentialing information may not be released to any unauthorized person or entity, nor may credentialing information be discussed with any unauthorized person outside the Credentials Committee or the MSS office. This does not preclude a practitioner from accessing his/her own credentialing information as outlined above.

Responses to external verification request for credentialing information are completed on the form supplied when possible or by standard verification letter which includes approximate date, staff category, department, and status.

Credential files are maintained in individual files in locked filing cabinets or specially designed areas with locked doors. Electronic Credential files are maintained on a secure server that requires individual authorization to access the information. Electronic communications receive the same protection as hardcopy documents regarding confidentiality and disclosure issues. The Medical Staff Services personnel must comply with all other relevant confidentiality policies.

IX. **Initial and Reappointment/ Credentialing or Re-Credentialing Application Requirements:**

<table>
<thead>
<tr>
<th>Initial Appointment / Credentialing requirements</th>
<th>Re-Appointment / Re-credentialing requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Washington State Medical License</td>
<td>Complete VMM Re-Appointment / Re-credentialing application</td>
</tr>
<tr>
<td>Complete VMM application</td>
<td></td>
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<tr>
<td>• With a minimum amount specified by the Governing Board ($1/3M)</td>
<td>• With a minimum amount specified by the Governing Board ($1/3M)</td>
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</tbody>
</table>
X. **Processing the Application** The Applicant shall have the burden of producing accurate and complete information for a proper evaluation of his/her experience, background, training and demonstrated ability, and physical and mental health status, and of resolving any doubts about these or any of his/her qualifications.

XI. **Verification Shall Include**

<table>
<thead>
<tr>
<th>Initial Appointment / Credentialing requirements</th>
<th>Re-Appointment / Re-credentialing requirements</th>
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<tbody>
<tr>
<td>Accredited Medical/Dental/Podiatric Education (may include, but not limited to, verification through the AMA, AOA, or ADA profile or directly through the specific school). Internship, Residency, Fellowship (may include, but not limited to, verification through the AMA, AOA, or ADA profile or directly through the specific training program).</td>
<td>Hospital or Facility Affiliations since last appointment/credentialing with VMM. For non-delegated telemedicine practitioners, 3-5 facilities that the practitioner has provided significant services to, will be queried.</td>
</tr>
<tr>
<td>Hospital or Facility Affiliations following completion of Medical/Professional education. (Exception, Locum Tenens or Telemedicine applicants, request for the past 10 years or sufficient to provide an accurate, quality perspective.)</td>
<td>Professional Licensing Board Status through the AMA or individual state.</td>
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<tr>
<td>Professional Licensing Board Sanctions or Limitation of any state in which the Applicant is currently or has previously been licensed to practice, through the NPDB or the individual State.</td>
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<tr>
<td>DEA registration through the Drug Enforcement Agency or receipt of DEA coverage plan</td>
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<tr>
<td>Professional references (as applicable)</td>
<td>Professional reference (as applicable)</td>
</tr>
<tr>
<td>National Practitioner Data Bank, the following exception shall apply: Allied Health professionals granted a scope of service would not require a National Practitioner Data Bank (NPDB).</td>
<td>National Practitioner Data Bank as part of continuous query, the following exception shall apply: Allied Health professionals granted a scope of service would not require a National Practitioner Data Bank (NPDB).</td>
</tr>
<tr>
<td>Confirmation of malpractice settlements via the National Practitioner Databank (NPDB).</td>
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</tr>
<tr>
<td>Board Certification by the AMA, AOA, or appropriate Certification Boards</td>
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</tr>
<tr>
<td>Criminal history queried through Washington State Patrol criminal background check and national/international criminal background check</td>
<td>Criminal history queried through Washington State Patrol</td>
</tr>
<tr>
<td>ECFMG- Education Commission for Foreign Medical Graduates (if applicable).</td>
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<tr>
<td>Work history, including written explanation of gaps of three (3) months or more, within the last 5 years.</td>
<td>Work history since last appointment/credentialing.</td>
</tr>
<tr>
<td>Liability coverage history verified through the Liability Carrier, and/or the National Practitioner Data Bank</td>
<td>Liability coverage history verified through the Liability Carrier, face sheet and/or the National Practitioner Data Bank</td>
</tr>
<tr>
<td>Current liability coverage and limits</td>
<td>Current liability coverage and limits</td>
</tr>
<tr>
<td>Medicare/Medicaid Sanctions and Excluded Providers through NPDB, AMA, OIG and SAM</td>
<td>Medicare/Medicaid Sanctions and Excluded Providers through NPDB, AMA, OIG and SAM</td>
</tr>
<tr>
<td>State Medicaid Excluded Providers through Streamline Verify and/or individual State exclusion list</td>
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</tr>
<tr>
<td>SSA Death Master List through the NTIS</td>
<td>SSA Death Master List through the NTIS</td>
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<tr>
<td>NPI validation through the NPPES.</td>
<td>NPI validation through the NPPES.</td>
</tr>
<tr>
<td>Medicare Opt Out through CMS.data.gov</td>
<td>Medicare Opt Out through CMS.data.gov</td>
</tr>
<tr>
<td>Other sources, depending upon background and experience.</td>
<td>Other sources, depending upon background and experience.</td>
</tr>
<tr>
<td>Quality Assurance findings regarding patterns of care relating to professional performance, judgment and clinical or technical skills.</td>
<td></td>
</tr>
<tr>
<td>Compliance with all applicable Bylaws, Rules and Regulation and Policies and procedures of the Medical Staff and Hospital.</td>
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</tbody>
</table>

**XII. Receipt of Application**

1. When an application has been submitted by the Applicant and is deemed complete to begin processing, a notification acknowledging receipt of the application will be sent to the Applicant.
2. If an Application has been returned and is deemed incomplete, the Applicant will be notified and provided an opportunity to submit the missing information. If the information is not
provided within ten (10) days of such notice, the application shall be treated as having been withdrawn.

XIII. Verifications Pending  
1. If after thirty (30) days, items are still pending, the Applicant will be notified of the need for assistance in gathering missing information.

2. If after another fifteen (15) days, the pending items have not been received, MSS will (after consultation with a member of the Credentials Committee or Department Chair, as necessary), request assistance from the Applicant describing the information pending and shall indicate the deadline by which the information is to be returned. The date may be modified to the extent necessary and reasonable. Failure of the Applicant to provide the requested information by the date required will result in termination of the application process. This is not reportable to the NPDB and the applicant shall not be entitled to the procedural rights provided in the Fair Hearing Plan.

XIV. Appropriate Documentation of Credentialing Verifications  
1. Credentialing verifications are tracked for completeness on a checklist system.

2. Verifications may be received by the primary source, an approved agent of that source, or a designated equivalent through original documentation, written verification, internet verification, fax verification, and/or verbal verifications.

3. Verbal verifications will be documented with the date, name of the organization or institution to be verified, name of the person providing the information, and the name of the VMM credentialing staff that received the information.

4. All verifications will be date stamped and signed or initialed by the VMM staff member processing the application, or otherwise electronically authenticated.

XV. Verifications Complete  
When collection and verification is complete, MSS shall transmit the application and all supporting materials to the Chairperson of each Department in which the Applicant seeks membership and/or privileges. The Applicant shall be so notified. **An application shall be deemed incomplete if any required items are missing or if the need arises for new, additional, or clarifying information in the course of reviewing an application.

XVI. Time Periods for Processing  
All verification and applicant signatures must be valid, current and not more than 180 days old at the time of the Governing Board’s final decision. Any verification or signature beyond 180 days at the time of the Governing Board’s final decision will be re-verified prior to decision.

All individuals and groups required to act on an application for Staff appointment must do so in a timely and good faith manner and, except for good cause, each application should be processed within the following time periods:

<table>
<thead>
<tr>
<th>Individual/ Group</th>
<th>Time Period</th>
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<tbody>
<tr>
<td>CEO/Medical Staff Services (collect/summarize)</td>
<td>60 Days</td>
</tr>
<tr>
<td>Department Chairperson (review/recommend)</td>
<td>15 Days</td>
</tr>
<tr>
<td>Credentials Committee (recommend)</td>
<td>31 Days after the applicant has been</td>
</tr>
</tbody>
</table>
POLICY

notified the application is complete

Medical Executive Committee (recommend) 31 days
Governing Board (final decision) 31 days
Applicant’s notification of the Governing Board Decision 10 days

These time periods are deemed guidelines and do not create any right to have an application processed within these precise periods and do not account for any deferrals allowed under this Policy by a Department Chairman or a Committee.

Final decision effective dates will be based on the date of the decision declared by the Governing Board.

XVII. Time requirement for Reappointment/ Re-credentialing Forms - Each Member requesting reappointment shall deliver his/her completed reappointment forms to MSS within fifteen (15) days of the notice of expiration. Extensions may be granted for an additional fifteen (15) days by MSS. Failure, without good cause, to return the forms to MSS shall be deemed a voluntary resignation from the Staff and shall result in automatic termination of Membership/Privileges at the expiration date of the Member’s current term of (re)appointment/ (re)credentialing.

No temporary privileges will be extended to practitioners whose reappointment processing has not been completed by the date of their membership or privilege expiration.

When collection and verification are complete, the reappointment approval process will follow as outlined above (Time Periods for Processing).

XVIII. Clean File Review All VMM files, including clean files, go through the same process for appointment and reappointment, with final approval by the Governing Board. This denotation is for the purpose of delegated credentialing only and has no bearing on the credentialing process as outlined in this policy.

For delegation standards, Clean Files are defined as routine information only; all “no” responses to professional practice questions on attestation. Data in the file supports provider’s responses. No adverse quality assessment evaluation information.

XIX. Department Chairperson: Department Chairperson’s Report - The Department Chairperson shall review the application. He/ She will schedule the interview with the Applicant, in person or by telephone, within seven (7) days and have the interview completed within fifteen (15) days. If the interview is not scheduled within seven (7) days, the Credentials Committee will be asked to facilitate the interview. In reviewing and submitting the report to the Credentials Committee, the Department Chair is acting as an agent or investigator for the Credential’s Committee. Interviews do not need to be performed on an AHP practicing under a scope of service, or AHP’s without hospital privileges. Furthermore, if an AHP applicant’s credentials file is deemed by the Department Chairperson to be free of any discrepancies, an interview is not necessary.

1. Favorable Findings: Department Chairpersons must document their findings pertaining to adequacy of education, training and experience for all privileges requested. References to
any criteria for privileges review must be documented. Specific reference to the credentials file should be made in support of all findings.

2. **Deferral of Report:** If a Department Chairperson requires further information, he/she may defer transmitting his/her report, for as many as thirty (30) days, except where more time is necessary and good cause exists for additional deferral, the applicable Department Chairperson must notify through MSS, the Applicant, the Chairperson of the Credentials Committee, and the Medical Staff President in writing of the deferral and the grounds. If the Applicant is to provide additional information or a specific release/authorization to allow hospital representatives to obtain information, the special notice to him/her must so state, must be a Special Notice, and must include a request for the specific data/explanation or release/authorization required and the specific date for response. Failure, without good cause, to respond in a satisfactory manner by that date is deemed a voluntary withdrawal of the application. In the event a Chairperson is unable to formulate a report for any reason, he/she must so inform the Credentials Committee.

3. **Unfavorable Findings:** Department Chairpersons must document the rationale for all unfavorable findings.

Special Notice defined: Written notification sent by certified mail, return receipt requested.

**XX. Credentials Committee Action** - The Credential Committee composition, function and duties are outlined in the Medical Staff Bylaws. The Credentials Committee meetings occur at least 10 times per year. (See Appendix 2 - Medical Staff Bylaws).

During the next Credentials Committee meeting, after receipt of the Department Chairperson’s Report, the Committee will review the content of the Applicant’s file and will conduct, unless previously done by the appropriate Department Chairperson, a personal and/or telephone interview with the Applicant. The Credentials Committee will then make a recommendation regarding Staff Membership and/or Privilege delineation to the Medical Executive Committee for transmittal to the Governing Board. The recommendation shall be made within thirty (30) days after the applicant has been notified that the application is complete.

1. **Favorable Recommendation:** When the Credentials Committee’s recommendation is favorable to the Applicant in all respects, the file shall promptly forward with the recommendation to the Medical Executive Committee.

2. **Deferral Recommendation:** Action by the Credentials Committee to defer the application for further consideration must be followed within forty-five (45) days by subsequent recommendations as to approval or denial of, or any special limitations to, Medical Staff appointment, category of Medical Staff and prerogatives, department affiliations, and scope of clinical privileges. The Credentials Chair or Medical Staff Services shall promptly send the Applicant written notice of an action to defer.
3. **Adverse Recommendation:** If the Credentials Committee determines that the applicant be denied, or that the scope of clinical privileges be less that those applied for, the reasons and supporting documents shall be forwarded to the Medical Executive Committee.

XXI. **Medical Executive Committee**
MEC Review and Recommendation at the next scheduled meeting, after receipt of the Credentials Committee’s Report and recommendation, the MEC shall vote:

1. **Favorable Recommendation:** When the MEC’s recommendation is favorable to the Applicant in all respects, the MEC shall promptly forward with the recommendation to the Governing Board.

2. **Deferral Recommendation:** Action by the MEC to defer the application for further consideration must be followed within forty-five (45) days by subsequent recommendations as to approval or denial of, or any special limitations to, Medical Staff appointment, category of Medical Staff and prerogatives, department affiliations, and scope of clinical privileges. The Credentials Chair or Medical Staff Services shall promptly send the Applicant written notice of an action to defer.

3. **Adverse Recommendation:** If the MEC determines that the applicant be denied, or that the scope of clinical privileges be less that those applied for, the Fair Hearing Plan shall be initiated. (*See Appendix 2-Medical Staff Bylaws; Appendix 3-Request for Investigation & Initiation of a Fair Hearing)*

If an MEC meeting is cancelled, action on credential items should not be deferred. Voting members of the MEC will be requested to review credentials items in the Medical Staff Office and provide a written vote. A simple majority will be sufficient to forward items to the Governing Board.

XXII. **Governing Board Action** - The Governing Board may adopt or reject, in whole or in part, a favorable or unfavorable recommendation from the MEC.

1. **Based on a Favorable Action:** In the event that the Board of Trustees’ decision is favorable to the applicant, such decision shall constitute final action on the application. The CEO or his/her designee shall promptly inform the applicant that his/her application has been approved. The decision to grant Medical Staff appointment or reappointment, together with all requested clinical privileges, shall constitute a favorable action even if the exercise of clinical privileges is made contingent upon monitoring, proctoring, periodic drug testing, additional education concurrent with the exercise of clinical privileges, or any similar form of performance improvement that does not materially restrict the applicant’s ability to exercise the requested clinical privileges.

2. **Deferral of Action:** The Governing Board may refer the recommendation back to the MEC for further consideration, stating the reasons for the referral back and setting a time limit within which a subsequent recommendation must be made.

As part of any of its actions outlined in this Credentialing Policy and Procedure Manual, the Governing Board may, at its discretion, conduct an interview with the Applicant, or designate
one or more individuals to do so on its behalf. If, as part of its deliberations, the Governing Board determines that it requires further information, it may defer action but for generally not more than thirty (30) days, except for good cause, and it shall notify the Applicant and the President of the Staff in writing of the deferral and the grounds for the deferral.

If the applicant is to provide additional information or a specific release/authorization to allow Hospital representative to obtain information, the notice to the Applicant must so state, must be a Special Notice, and must include a request for the specific data/explanation or release/authorization required and the time frame for a response. Failure, without good cause, to respond in a satisfactory manner by that date is deemed a voluntary withdrawal of the application and does not entitle the procedural rights provided in the Fair Hearing Plan.

3. **Adverse Action:** In the event of an Adverse Governing Board action on an Applicants credential file, a Special Notice will be mailed by a representative of the Governing Board to the Applicant, the Applicant shall then be entitled to the procedural rights provided in the Fair Hearing Plan.

4. **Adverse Governing Board Action defined:** Adverse action by the Governing Board means action to deny appointment or reappointment, or to deny or restrict clinical privileges.

5. **After Procedural Rights:** In the case of adverse MEC recommendation and a request for a Hearing, the Governing Board will take final action on the matter as provided in the Fair Hearing Plan.

**XXIII. Basis for Recommendation and Action:** The report of each individual or group, including the Governing Board, required to act on an application must state the reasons for each recommendation or action taken, with specific reference to the completed application and all other documentation considered.

**XXIV. Notice of Final Decision:**
1. The Applicant shall receive written notice of the Governing Board’s final decision of appointment or Special Notice of any adverse final decision within ten (10) calendar days of the Governing Board decision.

2. Decision and notice of appointment includes:
   A. The Staff category to which the Applicant is appointed.
   B. The Department to which he/she is assigned.
   C. The clinical privileges he/she may exercise.
   D. Any special conditions attached to the appointment.
   E. Notice of onboarding/orientation process.

**XXV. Application after Adverse Appointment Decision**
Except as otherwise provided in the Bylaws or as determined by the Credentials Committee, in light of exceptional circumstances, an Application or Member who has received a final unfavorable decision regarding, or who has voluntarily resigned to avoid an adverse action, or accepted a condition, limitation or restriction on, or withdrawn an application for appointment, Medical Staff category, Department assignment, or clinical privileges, is not eligible to reapply to
the Medical Staff or for the applicable category, Department assignment, or privileges for a period of twenty four (24) months from the date of the notice of the final unfavorable decision or the effective date of the resignation or application withdrawal. Any such reapplication shall be processed in accordance with the procedures set forth in this Policy. The Applicant or Member must submit such additional information as the Medical Staff and/or Governing Board may require in demonstration that the basis of the earlier unfavorable action no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be further processed. No Applicant or Member shall submit or have in process at any given time more than one application for initial appointment, reappointment, Medical Staff category, a particular Department assignment or the same clinical privileges.

XXVI. **Non-Discrimination**

Credentialing and re-credentialing decisions are made solely based on the results of the verification process.

Annually, the Credentials Committee signs an affirmation confirming that credentialing decision are not made based on an applicant’s race, ethnicity/national identity, religion, creed, gender, age, sexual orientation, disability, veteran’s status, procedure or patient type (i.e. Medicaid patients) in which the provider specializes, or any other basis prohibited by State and Federal law. Applicants’ demographic information is not provided to the Credentials Committee.

All Credentialing Applications are logged and their status (Approved/Denied) recorded.

Annually, MSS provides a summary report to the Credentials Committee. The purpose of the annual report is to review all credentialing denials; Credentials Committee members are instructed to assess whether or not discrimination played a role in any denial. The Credentials Chair is responsible for identifying trends in discrimination, and the Governing Board is responsible for ensuring that a corrective action plan has been implemented and followed if necessary.

**XXVII. Health Plan Delegated Credentialing additional requirements:**

1. **Adverse event and complaints** When there are questions about a provider’s individual performance, a Quality Assessment by the provider’s peers is initiated. Quality Assessment reviews are saved in the provider’s quality file and are reviewed every six months as part of Ongoing Professional Practice Evaluation (OPPE) and reappointment. (See Appendix 4-Medical Staff Peer Review OPPE/FPPE Policy)

2. **Notification to Authorities and Practitioner Appeal Rights** Action taken against a practitioner for quality reasons resulting in suspension or termination are reported to state licensing agencies, the NPDB and Delegated Credentialing payers pursuant to state & federal law, the NPDB Guidebook and payer contracts. The MSS is responsible for reporting to the NPDB and Washington State Department of Health. The Credentialing Specialist will notify the applicable health plans. Methods and time frames for notification of health plans are contained in the Delegated Credentialing Contracts.

Any adverse findings identified through ongoing monitoring and/or the credentialing/re-credentialing process, and the supporting documentation related to the findings, are collected and reported to the Medical Staff Leadership and/or Credentials Committee Chair.
based upon adverse findings will be in accordance with The Medical Staff Bylaws. Reporting of adverse actions such as practitioner suspension or termination to the appropriate licensing agency and/or the NPDB will be in accordance with state and federal law and legal counsel recommendation. If the practitioner does not request a hearing, a report summarizing the adverse action will be submitted to the NPDB and the Washington State Department of Health no later than thirty (30) days after the practitioner relinquishes his/her rights. If the practitioner requests a hearing and the final decision is adverse, the report will be submitted to the NPDB and the Washington State Department of Health no later than thirty (30) days after the hearing process has been completed.

Notification to delegated health plans will be made by MSS based upon the individual delegated credentialing contract.

3. **Ongoing Monitoring** All providers are monitored through the following:

<table>
<thead>
<tr>
<th>Monitoring Source</th>
<th>Frequency</th>
</tr>
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<tbody>
<tr>
<td>NPDB through continuous query</td>
<td></td>
</tr>
<tr>
<td>License limitations and sanction through NPDB continuous query</td>
<td></td>
</tr>
<tr>
<td>OIG, SAM/GSA monthly through Streamline Verify</td>
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<tr>
<td>Medicare/Medicaid sanctions and exclusions through Streamline Verify within 30 days of release by reporting agency</td>
<td></td>
</tr>
<tr>
<td>Medicare Opt Out Affidavit list through CMS.data.gov monthly</td>
<td></td>
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<tr>
<td>State Provider Termination and Exclusion through Streamline Verify or State, monthly, or with 30 days of release</td>
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<tr>
<td>SSA Death Master List through the NTIS via Streamline Verify on Initial credentialing and re-credentialing</td>
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<tr>
<td>Adverse Events or Complaints through OPPE, reappointment and Quantros Event Reporting system</td>
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</tbody>
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**XXVIII. Process for Sub-Delegating Credentialing and Re-credentialing**

*Sub-delegation will not consist of payer delegated providers.*

1. VMM may delegate credentialing and recredentialing activities to groups that meet VMM’s standard requirements as outlined in this Credentialing Manual.
2. All agreements will be mutually approved by VMM and the delegate.
3. VMM retains the right to limit or revoke any and all delegated credentialing activities when a delegate fails to meet VMM’s requirements.
4. VMM retains the right to approve, suspend and terminate delegated practitioners or providers.
5. VMM will, at least annually, audit the delegate to ensure all VMM requirements are being met with at least a 90% score of accuracy.
6. The delegate will provide electronic copies of appropriate credentialing materials and other reasonable evidence of compliance with VMM’s standards for credentialing upon VMM’s request.
7. The delegate will correct any deficiencies identified during the audit or as noted on a Practitioner’s credentialing file.
8. The delegate will maintain and provide a current roster of Practitioners and will send an updated roster for additions, terminations or changes as they occur.
9. VMM remains responsible for querying the NPDB.
XXIX. **Office site visits** - The Health Plans which delegate their credentialing to VMM’s Medical Staff Services set the thresholds for office-site criteria and medical/treatment record-keeping practices for all practitioners within its network. These criteria address physical accessibility, physical appearance, adequacy of waiting room and examining room space, availability of appointments, and the adequacy of treatment record keeping.

Sites visits are conducted by a VMM designated employee when member complaints are received. The health plans require action to improve offices that do not meet thresholds. These action plans are evaluated every six (6) months or until the deficient office meets the thresholds. Member complaints are monitored and site visits are performed within sixty (60) days of determining if the complaint threshold was met. Any follow-up visits for offices with subsequent deficiencies are documented.

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**Effective Date:** 6/26/2018  
**Term Date:**

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<tr>
<th>Governing Department:</th>
<th>Medical Staff</th>
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<tr>
<td>Sponsor:</td>
<td>Martin Brueggemann, CMO</td>
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<tr>
<td>Authored By:</td>
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</tr>
<tr>
<td>Revised By:</td>
<td>Rita Keller, MSS Manager</td>
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<td>Next Review Date:</td>
<td>6/26/2019</td>
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