STONY BROOK UNIVERSITY HOSPITAL
CREDENTIALING POLICY

Stony Brook University Hospital (SBUH) has established policy guidelines for credentialing and recredentialing providers of patient care services at this institution. These guidelines ensure that physicians/dentists (MD, DO, DMD, DDS) and other health care practitioners (nurse practitioners, nurse midwives, psychologists, physician assistants, podiatrists, speech pathologists, audiologists, neuropsychologists, optometrists, orthotists, certified registered nurse anesthetists [per medical board decision May, 2003]) appointed to serve our patients will meet uniform standards of education, specific training and experience, current competence and ability to perform the privileges assigned to them.

The policies and procedures delineated below have been established by the Medical Executive Committee of the Medical Board (MEC) in accordance with all applicable regulatory and accreditation standards, such as the University Hospital Medical Staff Bylaws, the New York State Department of Health, the Joint Commission on Accreditation of Healthcare Organizations, the National Committee for Quality Assurance, etc. The MEC and the Medical Board will review changes to this policy.

SBUH does not sub-delegate credentialing or recredentialing.

CREDENTIALING PROCEDURE

Standards for Participation

- All applicants (except Physician Assistants and Certified Nurse Anesthetists) must possess a faculty appointment in the School of Medicine or Dental Medicine to be eligible to apply for appointment to the medical staff and/or privileges in the hospital. (Interim appointments are granted for 120 days pending faculty appt – this appointment is with full privileges as approved. Practitioners applying for the category of Affiliate/Referring with Outpatient Privileges must possess a current faculty appointment at the time of appointment review.)
- All applicants shall submit a completed medical staff application form with appropriate documentation as requested on the application form. This includes signed statements and a release of information page.
- All applicants shall allow for applicable facility on-site review of their records and medical record keeping practices as designated by the rules and regulations of the medical staff and the facility.
- All applicants must be fully licensed and currently registered (or certified) in New York State.
- All applicants should have a current unrestricted DEA registration, if applicable to their specialty and practice. Applicants with pending DEA's may be appointed provided the Chief of Service delegates another practitioner for prescribing.
- All applicants must possess a current and valid certificate of infection control training as authorized by the State of New York.
- All applicants must submit a complete SBUH physical examination form that will be reviewed and maintained by Employee Health Services.
- All applicants will remain eligible to treat our Medicare and Medicaid patients if they remain free of any sanctions imposed by the Medicare/Medicaid or other governmental health related program.
- All applicants must have at least the minimum professional malpractice insurance with limits as defined by the SBUH Medical Staff Bylaws, Rules and Regulations and any other hospital requirement.
- All applicants must submit a complete work history (CV), chronologically outlined from graduation to the present.
- All applicants must provide, on their completed application, a full disclosure of malpractice history for the past ten (10) years, including any cases that are pending/outstanding in any state where the applicant has practiced.

CREDENTIALING/RECREDENTIALING CRITERIA

The following information will be reviewed/queried at the time of appointment or reappointment.

Credential	Source	Method	Periodicity
NYS Licensure Other state licenses	NYS Education Dept and/or Federation of State Med Bds	Internet query	NYS - Upon application, reappointment & date of expiration Other states – Upon appointment
DEA	DEA	Query NTIS on Internet Copy of original	Upon application, reappointment & date of expiration (currently not required at appointment if applied

			for)
Education - graduate of medical/dental or other professional school	Medical/Dental professional school registrar or AMA Physician Profile	Direct query with AMA or school registrar	Upon application
Post-graduate training	Resident and/or fellowship program director	Direct query - AMA Physician Profile or program/institution	Upon application & reappointment, if applicable (NYS 2805K law)
Board Certification	Specialty Boards	Direct query – Certifacts or ABMS Compendium or AOA internet (if applicable)	Upon application, reappointment, or change in status or expiration
Malpractice Insurance	Clinical Practice Management Plan or Respective dept	Copy of insurance binder/certificate	Upon application, reappointment & expiration date
Peer Recommendation	Residency/Fellowship Director or appropriate peer who has knowledge of applicant's current clinical competence.	Two recommendations will be solicited by the MSO from peers who can attest to the clinical competence of the applicant and ability to perform the procedures requested. (the request for privileges form completed by the applicant is submitted with the request for a competency judgment.	Upon application for all applicants and at reappointment, for low volume/no activity practitioners as determined by the individual service.
Licensure Sanctions	NY State Office of Professional Medical Conduct	Internet.	Upon application, reappointment & expiration date of NYS license via OPMC website. Reports from OPMC are also checked as frequently as they are available on the internet or via email. If a physician receives any sanctions, the medical director and the chief of service are immediately notified. Depending upon the sanction, appropriate action will be taken (ie., report to the MEC, Medical Board and Governing Body-reference to Bylaws)
Malpractice Claims History	Application (appointment and reappointment), NPDB 2805K responses	Direct query NPDB, hospital affiliations per 2805 regs, and carrier when possible	Upon application & reappointment
Hospital clinical privileges	Application (appointment and reappointment)	Direct query with hospital – 2805 letter	Upon application & reappointment

Work history gaps	Application and/or CV	Direct query with source/ explanation from applicant	Upon application
Attestation regarding health status	Health form with application	Delivered to Employee Health Service for clinical review	Upon application & annually thereafter (health form)
Medicare & Medicaid Sanctions	National Practitioner Data Bank/ OIG Database/AMA Profile	Electronic query	Upon application, reappointment and monthly as available
Infection Control Certification	NY State Approved Course Certificate	Visual inspection of certificate	Upon application & expiration date
Criminal Background Check	Carco	Electronic query	Appointment
Medicare Opt Out List	Empire/GHI http://www.empiremedicare.com/bene/optny/optout.htm http://www.ghimedicare.com/bene/opt_outs.html	Electronic query	Upon application, quarterly, and at reappointment
Practitioner Identification	Original government issued photo presented in person to MSSD or departmental representative	Identify practitioner, complete form, copies to file	Upon appointment
Workman's Compensation (10/05)	***http://www.wcb.state.ny.us/content/main/hcpp/wc09000.htm***	*Electronic Query*	*Upon appointment. If the practitioner is not listed at the time of appointment, the website will be verified upon notification that the practitioner has been accepted as an authorized provider*

CONFLICTING INFORMATION/INFORMATION REVIEW BY PRACTITIONER

The practitioner will be sent a letter at the time the application is received in the Medical Staff Services Dept (MSSD) advising him/her that the application has been received, and elements that are missing. The practitioner has the right to review his/her entire application, with the exception of peer review/faculty reference letters or any document which has been submitted to the MSSD and is marked confidential and the National Practitioner Data Bank response. The letter will also state that upon request, the applicant will be advised of the status of their application, by telephone.

The practitioner will be notified via mail, email or phone call if primary source verification data is not in agreement with information submitted in the appointment application package. The practitioner will have two weeks to correct this information with an explanation. All corrected information must be primary source verified. Corrected information shall be submitted in writing, via fax, email or mail, to the MSSD. The practitioner will be notified in writing, via fax, email or letter, when the corrected information has been received.

LEVELS OF REVIEW

Appointment to the Medical Staff and approval of privileges will follow the review process delineated in the Medical Staff Bylaws, Rules and Regulations, Article II, Section 3B. Levels of Review.

Once an application has been processed and determined to be complete* by the MSSD, the file is submitted to the respective department. The file is reviewed at the applicant's level of specialty, by the Division Chief, (if one exists). The file is then reviewed by the Credentials Committee which considers the completed application and supporting materials, makes such investigations as it deems proper and necessary, and makes a recommendation, including specific

recommendations for delineating the applicant's clinical privileges to the Chief of Service. The file is then reviewed by the Chief of Service and his/her recommendation is submitted to the MEC and Medical Board who then recommends to the Governing Body for final approval.

**Complete file is defined as a file that contains: primary source verification for licensure, DEA (if applicable), board certification (if applicable), education and residency/fellowship training, work history; NPDB response; queries to OIG, OPMC, and hospital affiliation(s); peer references; infection control certificate; completed application, photo and privilege sheet (if applicable); clearance from Employee Health Service; indication of malpractice coverage, delineation of malpractice cases since inception of training. A gap exceeding three months must be reviewed and clarified by the applicant and documented in the file.*

Administrative Privileges may be granted to a health care practitioner while waiting final approval by the MEC, Medical Board and Governing Body. Such privileges are granted only when the practitioner has completed the credentialing process, the Division Chief, if applicable, Credentials Committee and Chief of Service have reviewed the application and have recommended appointment. Practitioners who are granted administrative privileges will be granted provisional credentialing (per NCQA regs). Physicians will not be permitted to see patient members of any managed care company which delegates credentialing to SBUH until the credentialing process is completed and they have received final approval by the Governing Body, **unless** they have been provisionally credentialed as defined above.

Once the Governing Body grants approval, the applicant will be sent a letter of appointment. The letter of appointment will be sent to the applicant within 60 days of the Governing Body approval.

All applications for medical staff privileges will be completed within 180 days of the signature of the applicant. All verifications will be completed within 180 days. In rare cases, if the application is not completed within 180 days, the applicant will be asked to attest that nothing in their clinical practice has changed, or if there have been changes to indicate such changes. The applicant will review his request for privileges and indicate that there are no changes.

DATA VERIFICATION

For verification purposes and to ensure that listings in rosters, directories, etc are accurate, after the practitioner is appointed to the staff, he/she will be sent a verification form indicating the education, training, board certification and specialty information that has been input into the medical staff database (eff 5/05). The practitioner will be asked to verify the information and contact the MSSD with any revisions/corrections. Any corrections/revisions to data received from the practitioner will be reviewed with data currently in the database and in the practitioner credential's file. All data must be primary source verified. If this is additional data, not previously identified, primary source verification must be completed. (Note: Data contained in the medical staff database (Visual Cactus) is the source of data utilized by the managed care department for reporting to managed care companies.

REAPPOINTMENT

There is a process in place to review each practitioner credentialed through the MSSD every **two** years. However, a two-year review does not eliminate ongoing surveillance and review of quality issues presented during the two years prior to reappointment. Reappointment is alphabetical and occurs quarterly (reappointment date is tracked in Visual Cactus database). The practitioner receives notification of this review and is sent a reappointment application to complete. S/he is expected to sign off on the reappointment application that contains, among other things, a request for updated physical and mental health status, and an attestation of lack of impairment due to chemical dependency/substance abuse. The file will first be reviewed in the MSSD that does primary source verification (see table above). Additionally, education, training, experiences and competencies since the last appointment or reappointment are reviewed and if applicable, primary source verification is done. If previously agreed to, managed care companies will be queried in advance of the reappointment for quality information (patient complaints) that the managed care company wants included in the reappointment package (pertains to practitioners for whom the MSSD does delegated credentialing). Any information submitted will be included. A checklist will be used to indicate the date information was received in the MSSD. The medical staff office will also utilize a checklist to indicate the date all required items were verified to be current and in good standing. A date stamp will be used on all incoming mail. Documents received via the fax, will automatically have

a date and time printed on them from the fax machine. A reappointment file is only submitted to the department when it is determined to be complete. A complete file includes at a minimum:

- Complete reappointment application
- Request for privilege form (with the exception of Affiliate/Referring category)
- Malpractice Summary Sheet citing actions within the past 2 yrs, if applicable
- National Practitioner Data Bank Query Response
- CME information submitted by practitioner
- Clinical activity log from SBUH for practitioners with activity at SBUH
- Verification responses (per NYS law 2805) from other hospital affiliations
- Quality assurance data, including adverse events, which are specifically attributed to the practitioner. A checklist will be included indicating if there is no information to review; (i.e., practitioner has had no quality issues, practitioner has not had any mortality/morbidity reviews, practitioner has not had any patient complaints, etc since the last appointment/reappointment).
    - Summary of QA reviews
    - Mortality and morbidity reviews
    - NYPORTS data
    - Comparative UHC database report
    - QA data submitted by managed care companies
    - Surgical site infection rates if applicable
    - Patient complaints
    - Patient satisfaction survey data (available only when there has been >7 survey responses) (*SBUH utilizes Press Ganey to collect patient satisfaction data based on survey/questionnaire results)*
    - Actions by any regulatory agencies
    - Disciplinary reviews
    - Medical record delinquencies
- Other materials deemed pertinent to the reappointment of this practitioner
- A checklist completed by the MSSD indicating:
    - Primary source verification of current licensure, DEA, if applicable, malpractice insurance, infection control training, board certification status
    - Verification of current annual health assessment reviewed by Employee Health Service
    - Query conducted for Medicaid/Medicare exclusions (OIG database) and Professional actions by the Office of Medical Professional Conduct

For low volume/no activity practitioners who are requesting privileges, the respective department will request that the practitioner contact the Chief of Service or appropriate peer at their primary affiliation and request that they submit to the SBUH department, a reference attesting to clinical competency. This information will be collected by the respective department and included in the reappointment file.

The complete file is submitted to the department for the same levels of review as the appointment process**.** Specifically, the Division Chief, if applicable, and the Chief of Service will review the file and complete an Assessment of Competence for the Practitioner (attached). The Credentials Committee will review the file and complete the Credentials Committee Reappointment Assessment (attached). The entire file and the completed forms will be submitted to the Chief of Service for review, signature and recommendation.

Once the Governing Body grants approval, the applicant will be sent a letter of reappointment and a copy of the privileges granted, if applicable. The letter of reappointment will be sent to the applicant within 60 days of the Governing Body approval.

REDUCING, SUSPENDING, TERMINATING PRIVILEGES

There is a mechanism in place for reducing, suspending or terminating practitioner's privileges. It is described in detail in Article II, Section 6 and Article III of the Medical Staff Bylaws. It describes the appeal process for use by the practitioner. SBUH reports the reduction, suspension or termination of practitioner privileges to the appropriate outside agencies in accordance with applicable law, accreditation standards and the process dictated by the respective agency (see reporting adverse actions).

NON-DISCRIMINATORY CREDENTIALING DECISIONS

Healthcare practitioners are appointed/reappointed/granted privileges based on the need for their services consistent with the objectives and programmatic needs of the institution. Appointment or reappointment to the medical staff shall not be denied to any individual for reason of sex, race, national origin, creed, color, age, marital status, sexual preference, the types of procedures or patients the practitioner specialize in, or disability, except where that disability renders the person incapable, despite reasonable accommodation, of performing the essential functions of the medical staff appointment. The MSSD will conduct a quarterly audit of denied practitioner applicant files, non-reappointment and terminated practitioner files to ensure that practitioners are not discriminated against. Findings indicating possible discrimination will be reported to the Medical Board. Additionally, members of the credentialing committee may not participate in the review of a provider in which their judgment may be compromised/influenced due to their relationship with the provider.

CONFIDENTIALITY OF CREDENTIALS FILES

CONFIDENTIALITY POLICY FOR THE MEDICAL STAFF SERVICES DEPARTMENT

The records of the medical staff services department shall be considered confidential. They may be reviewed upon appropriate request and the approval of the President of the Medical Board or the Medical Director.

The hard copy of the credentials files reside in the MSSD, which has daily security patrols by Public Safety. Personal ID and passwords allow entry by the staff to the computer databases in the MSSD. These are changed intermittently. If an employee leaves, their password is deleted. Back-ups of the system take place on a regular basis by office staff and Information Technology.

The medical staff office is open from 8:30 a.m. - 5 p.m., Monday through Friday, except for major holidays. These rooms are never left unattended without being securely locked.

Personnel are told during their orientation about the importance of file confidentiality and it is written in their job description that is reviewed annually during their evaluation. All personnel complete HIPAA training.

With approval from the medical director, the practitioner has the right to review his credentialing file. The practitioner does not have the right to review any documentation that has been submitted and marked confidential by the submitter (i.e., faculty appointment letters that the writer has marked confidential). The practitioner does not have the right to view the NPDB response.

CONTENT OF FILES

The entire contents of the appointment and reappointment files will be maintained until the practitioner is no longer on the medical staff.

PHYSICIAN SANCTIONS – LICENSURE, OIG EXCLUSIONS, DISCIPLINARY ACTIONS

SANCTION QUERY TIMEFRAME:

LICENSURE: All NYS licenses are primary source verified through the New York State licensing board at the time of appointment, reappointment, and expiration. Documentation of queries will be indicated with the initials of the verifier.

OPMC: OPMC is primary source verified for license sanctions at appointment, reappointment and licensure expiration and whenever received via email notifications (dlp02@health.state.ny.us). Documentation of queries at appointment, reappointment and expiration will be indicated with the initials of the verifier on the NYS license verification on the reference to the OPMC website.

OIG: OIG exclusions are reviewed via the OIG database at the time of appointment, reappointment and as frequently as a new exclusion list is posted to the website.

ACTION ON ADVERSE INFORMATION

Any adverse information obtained from the above mentioned sources (license revocation, suspension, revocation, restriction, probation, loss of Medicare/Medicaid provider status, failure to comply with DOH mandated requirements, loss of malpractice insurance) is **immediately** referred to the Chief of Service, the Medical Director, the MEC, Medical Board, and the Governing Body. The procedure for review and action on adverse information received from these sources adheres to the procedures set forth in the University Hospital Medical Staff Bylaws, Rules and Regulations (Article II and III).

REPORTING ADVERSE ACTIONS

SBUH conforms to the requirements and procedures for reporting adverse clinical privilege actions as dictated by the National Practitioner Data Bank. (reference: http://www.npdb-hipdb.com/pubs/gb/NPDB_Guidebook_Chapter_E.pdf, pgs E-17-23). Copies of NPDB adverse action reports are also submitted to the Office of Professional Medical Conduct, 433 River St., Troy, NY 12180, Attn: Intake Unit. A copy of the adverse action report is maintained in the practitioner's confidential credentials file. Information concerning the action is also maintained in the medical staff database. The Medical Director, President of the Medical Staff or Associate Director for Medical & Regulatory Affairs is responsible for reporting adverse actions.

ONGOING MONITORING

Patient/visitor complaints within the hospital as well as those received from any managed care company, will be reviewed in accordance with the Administrative Policy on Patient/Visitor Complaints (RI:0005). Adverse events and/or quality issues regarding a practitioner will be reviewed in accordance with the Medical Staff QA process outlined in the Medical Staff Bylaws, Rules and Regulations, and the Administrative Policies on Quality Management (LD: 0043) and Sentinel Events (LD 0064).

Changes to this credentialing policy will be submitted to and approved by the MEC, Medical Board and Governing Body.

PRIVILEGING FOR PROCEDURES

All members of the medical staff shall be eligible for clinical privileges as demonstrated by their individual education, training, experience and competence, and as recommended by the Credentials Committee, the Chief of Service, the MEC, Medical Board, and approved by the Governing Body. These privileges must be consistent with the objectives and programmatic needs of the medical center. No member of the medical staff shall be permitted to perform any diagnostic or therapeutic procedure, which does not fall clearly under the commonly accepted and established guidelines of their specialty and has not been specified in the delineation of privileges, except in an emergency. In an emergency, a medical staff member is authorized to do everything possible – to the degree permitted by his or her license, but regardless of his or her department affiliation, staff category or level of privileges, to save a patient's life or to save a patient from serious harm.

It is the responsibility of each applicant to establish their qualifications and competency for the clinical privileges desired or requested.

SBUH utilizes the core privileging approach to delineating privileges. Core privileging involves specifying for each specialty a group of procedures and/or treatments (a combination of medical assessment and management as well as procedures) that a practitioner would almost always be qualified to perform upon completion of residency training in a particular specialty. Unless there is evidence to the contrary, every recent graduate of a specialty residency should be granted the core privilege for his or her specialty area. Practitioners who have not recently completed a residency training program would be qualified based upon practice experience in their specialty. These procedures together form a single privilege, called the core privilege, for the specialty. Core privileges are described in a simple, straightforward paragraph. A list of core procedures, included but not limited to, is delineated for reference only. Criteria for requesting Core Privileges is also delineated on each privilege sheet. In instances where "the equivalent as defined by the Chief of Service" is considered as criteria, the "equivalent as defined by the Chief of Service" is interpreted to mean: for those practitioners who have not completed a residency/fellowship program which allows them to be board certified or

considered board admissible, foreign training, unaccredited fellowship training, peer recommendations, prior experience, foreign board status, and/or recognition in field of expertise is considered.

There are usually special procedures or medical management of conditions that are not part of the core because they are either new, high risk or require additional training and experience. These procedures are referred to as Category 1 or Category 2 on the privilege sheets. Criteria for requesting these privileges are delineated on each privilege sheet.

Renewal of Privileges.

Clinical privileges will be renewed every two years at the time of the reappointment. The practitioner will be required to submit a request for privileges with consideration to their current clinical practice. Consideration of renewal of privileges will be based on the information contained in the reappointment file as delineated in this policy.

Increase of privileges.

Requests for an increase or a new privilege, which was not previously requested and/or reviewed, will require documentation of competency as delineated by the department and will follow the same level of review as delineated for appointment and reappointment. License verification and NPDB query will be conducted by the MSSD.

General Privileges for Active Attending Physician appointed to the medical staff.

All active attending physicians of the medical staff are automatically granted privileges to:

1. Admit patients, except for services which do not admit patients (i.e. Pathology and Emergency Medicine)
2. Perform histories and physicals
3. Order diagnostic and therapeutic services
4. Make referrals and request consultations
5. Provide consultations within the scope of his or her privileges
6. Use all skills they are currently competent to perform.
7. Render any care in a life-threatening emergency

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