<table>
<tr><td>This policy applies to:<br>☑ Stanford Health Care<br>☑ Stanford Children's Health</td><td>Date Written or Last Revision: Dec 2018</td></tr>
<tr><td>Name of Policy:<br>Credentialing and Privileging of Medical Staff and AHP/APP</td><td rowspan="2">Page 1 of 15</td></tr>
<tr><td>Departments Affected:<br>All Departments</td></tr>
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## I. PURPOSE

To establish mechanisms for gathering relevant data that will serve as the basis for decisions regarding credentialing and privileging of licensed independent practitioners who provide patient care services at Stanford Health Care ("SHC") and/or Lucile Packard Children's Hospital Stanford ("LPCHS") ("Hospitals"). This policy applies to all medical staff members at SHC and LPCHS as well as Allied Health Professionals/Advanced Practice Provider credentialed and privileged through the Medical Staff Services Department ("MSSD").

## II. POLICY STATEMENT

It is the policy of SHCand LPCHS to ensure that licensed independent practitioners meet the minimum credentials, privileging and performance standards. Credentialing is performed jointly for all physicians, podiatrists, psychologists and dentists prior to appointment to the SHC or LPCHS Medical Staff. Credentialing and Privileges is performed jointly for all AHP/APP prior to approval by the Governing Body. Credentials and Clinical Privileges are approved separately by each hospital to which the practitioner is applying. Members of the Medical Staff may be granted delineated clinical privileges as specified in the Medical Staff Bylaws for each facility.

The providers attest that all information submitted for the credentialing and privileging process is accurate, and agree to report immediately any change in status of the information maintained in the Credentials files. If any submitted items differ from documentation disclosed through the verification process, the Credentials Committee(s) or Interdisciplinary Practice Committee ("IDPC") may consult with the provider to resolve discrepancies.

All applications for appointment, reappointment, and requests for clinical privileges, will be evaluated based on current licensure, education, training or experience, current competence, and ability to perform the clinical privileges requested. AHPs are credentialed according to NCQA guidelines.

## III. DEFINITIONS

- Advanced Practice Provider (APP) - Health care personnel, who are not eligible for medical staff membership and who are qualified to provide clinical services to patients. These providers are typically privileged and required to have a supervising physician as per the AHP policy.

- Allied Health Professional (AHP) –Health care personnel who are Clinical Specialists, not eligible for medical staff membership, and who are qualified to provide clinical services to patients. These personnel do not have privileges and are credentialed for billing purposes as per the AHP policy.

- National Committee for Quality Assurance (NCQA) – NCQA is a regulatory agency that monitors the quality of health plans. All providers listed on health plan rosters that LPCHS contracts with are credentialed according to NCQA requirements.

- National Practitioner Databank (NPDB) – NPDB is a confidential information clearinghouse that includes adverse action, medical malpractice payment, and judgement or conviction reports provided by entities to help prevent fraud and abuse and protect the public.

## IV. PROCEDURES

A. Delegation
Stanford Health Care and Stanford Children's Healthcare do not delegate credentialing activities. SHC MSSD is contracted with health plans to be the delegated entity for those organizations, which NCQA guidelines are applied.

B. AHPs are credentialed according to NCQA guidelines.

C. New Applicants
Individuals requesting to be credentialed and privileged will be provided a link to the New App Request Form. Once that form is completed they will receive a link to their own personalized Practitioner Home Page ("PHP") or Practitioner Portal in an e-mail outlining the time frame and basic requirements for processing the request. Content of the website includes:

1. Application including licensure information on any active or inactive licenses, DEA registration, Work History and complete information for Peer References

2. Attestation Questionnaire: including applicant attesting to reasons for inability to perform the essential function of the position with or without accommodation, lack of present illegal drug use, history of loss of license and/or felony convictions, and history of loss of limitation of privileges or disciplinary activity. This statement provides attestation to the correctness and completeness of the application.

3. Authorization to Release Information Form which includes consent to release information to Contracted Health Plans if the applicant participates in the SHC or LPCHS Health Plan Contract.

4. Insurance Liability Questionnaire

5. Claims Status to be completed for each Open or Closed Claim

6. Health Screening Requirements Statement with Contact Information

7. Background Check Release Link

8. Continuing Education Attestation

9. Confidentiality and Conflict of Interest Statement of Compliance

10. Medicare Acknowledgement Statement

11. Code of Conduct and Professional Behavior

12. Important Contact Information

13. Privilege Forms (if applicable)

14. Training Modules; including, Getting to Zero, Sedation, HIPAA, QI, Electronic Medical Record for SHC and LPCHS (as applies)

15. Policies and Procedures link

16. *Medical Staff Bylaws, Rules and Regulations link*

17. *State of CA Abuse Form*

18. The hospital verifies that the practitioners requesting approval is the same practitioner identified in the credentialing documents by completing a Photo Identification Form or providing a government issued ID to the Photo ID/Security Department as described in their policy 'Badge – Identification Policy'.

19. 2x2 Photo required to be included on Privileging Module

In order for a practitioner to be credentialed and privileged, he/she must submit a completed application form along with other documents requested in the application packet. The application must be completed in its entirety.

C. Reappointments

Reappointment to the Medical Staff and requesting of clinical privileges shall occur biennially.

Applications will be sent to providers five (5) months prior to their appointment expiration date and are expected to be completed and returned within 5 weeks.

The practitioner shall be required to submit an attestation for completion of continuing education activity for the previous two years, clinical privilege request form for each facility, complete information for Peer Reference and any other documentation/ information requested. All reappointment applications will also include an Attestation Questionnaire as outlined in Section III.A.2 of this policy.

If the provider fails to submit a completed application packet as outlined in electronic communication he/she shall be deemed to have voluntarily resigned his/her Medical Staff membership. The procedural rights set forth in the Medical Staff Bylaws for each facility shall not apply to a voluntary resignation under this section.

D. Timeliness of Information

Any of the following information found to be beyond 180 days of the signed authorization , at the time the file is presented to the Credentials Committee(s) or IDPC will be re-verified prior to review by that committee:

- All online verifications
  - CA Medical or Professional License(s)
  - CA Furnishing License
  - DEA (Drug Enforcement Administration)
  - NPDB (National Practitioner Data Bank)
  - OIG (Office of Inspector General)
  - GSA (General Services Administration)
- Answers to attestation questions
- Signature and date on authorization to release form
- Malpractice Claims Verifications (for AHPs use NPDB report)

E. Approval

1. The application, privilege request form and supportive documentation are sent to the appropriate Department Head/Service Chief/Division Head for review and recommendation to the Credentials Committee(s) or IDPC. If the Department Head/Service Chief/Division Head is disinclined to make a favorable recommendation for these membership/privileges, the Department Head/Service Chief/Division Head shall send a letter to the Credentials Committee(s) or IDPC indicating his or her concerns.

2. The evaluation and approval for additional privileges is forwarded to the Credentials Committee(s) or IDPC, with final review and approval by the Medical Executive Committee (MEC) and Governing Board.

F. Requests for Additional Privileges

Any provider may request additional privileges at any time. These requests are handled as follows:

1. The provider must complete the appropriate privileging form and supply supporting documentation regarding training or experience, as required.

2. The following must be verified
   - CA Medical or Professional License – MBC (Medical Board of California)
   - Additional CA State License
   - CA Furnishing License
   - DEA (Drug Enforcement Administration), if applicable
   - NPDB
   - OIG (Office of Inspector General)

3. The privilege request form and supportive documentation are sent to the appropriate Department Head/Service Chief/Division Head for review and recommendation to the Credentials Committee(s) or IDPC. If the Department Head/Service Chief/Division Head is disinclined to make a favorable recommendation for these privileges, the Department Head/Service Chief/Division Head shall send a letter to the Credentials Committee(s) or IDPC indicating his or her concerns.

4. The evaluation and approval for additional privileges is forwarded to the Credentials Committee(s) or IDPC, with final review and approval by the Medical Executive Committee (MEC) and Governing Board.

G. Changes of Status, Resignations, and Retirement

A status change may be initiated by the Department Head/Service Chief/Division Head or the Credentials Committee(s) to assure that the member meets the qualifications for medical staff membership under his or her membership category. In addition, the provider may request a change of status at any time. All requests must be in writing.

## V. PROVIDER RIGHTS TO AMEND APPLICATION AND TO RECEIVE UPDATES

A. Providers have the right to correct erroneous information obtained throughout the credentialing process. If any submitted items differ substantially from documentation disclosed through the verification process, the provider will be asked via written request (email or certified letter) to resolve this discrepancy and will be expected to do so within 10 business days of the request. Any and all corrections should be submitted in writing to the SHC/LPCHS MSSD for adequate review of current documentation. Any instance of the provision of information containing misrepresentations or omissions is forwarded to the Credentials Committee(s) for review and action. The provider will be notified of any actions following review by the Board of Directors.
Providers are allowed access to their own credentials files (with the exception of Peer Evaluations or verifications) as outlined in the policy for Confidentiality of Medical Staff/ AHP/APP Records.

B. Providers have the right to contact MSSD at any time regarding the status of their application for appointment or reappointment. All such requests will be responded to by the appropriate coordinator within a reasonable period of time, not to exceed four work days.

## VI. PROCEDURE

A. Processing and Verification

When the application for appointment or reappointment is returned, a review for completeness is performed by the Credentialing Office. If additional information is required, or if questions are left blank, the applicant is contacted and informed that processing will not begin until the application is entirely complete. The applicant is responsible for providing the information to satisfy the process. Failure to submit the requested information within 10 days shall be considered a withdrawal of the application.

All information gathered on the application will be verified by the primary source. Primary source may include verbal verifications which require a dated, signed note in the credentialing file stating who at the primary source verified the item, and the date and time of verification.

In addition, queries will be made to the NPDB and the MBC regarding any adverse actions against the practitioner. If any verification received has adverse actions, the practitioner will be promptly contacted and will be expected to provide an explanation in writing for any of these issues. Sources used for verifications include:

1. <u>California Professional License /Professional Licenses from Other States</u>

Current California State professional licensure must be obtained by direct confirmation from the appropriate licensing board either on-line, or by phone. Boards used for verification:

- State of California Medical and Professional Board– this verification confirms successful graduation from medical school and completion of at least one year of postgraduate residency training.
- Other State Medical and Professional Boards for active professional licenses

2. DEA Certification

An on-line NTIS query is required for primary source verification. All SHC/LPCHS providers must have a valid DEA certificate, including all schedules (2, 2N, 3, 3N, 4 and 5), with a California address. As are others as noted in the SHC/LPCHS Bylaws. For Advance Practice Professionals, DEA requirements are based on scope of service. Providers who are required to have a DEA, with an expired DEA, limited schedules or out of state address will have their privileges suspended until evidence of a valid DEA is provided to the MSSD.

A practitioner with an out-of-state address on their DEA may be credentialed pending the change of address or additional request for a DEA in the state of California, if proof of request has been received by the MSSD

The SHC/LPCHS Pharmacy is notified on a monthly basis of all expired DEA certificates.

3. Fluoroscopy Certificate

Required for all radiologists and non-radiologists who will be using fluoroscopy equipment in the operating rooms or other procedure areas. Radiography Certificate is not accepted as a Fluoroscopy Certificate.

4. Verification of Hospital Affiliations and Work History

Written verification of five (5) years of clinical work history from hospitals or other health care organization affiliations is required for initial appointments (2 years for reappointment). Verification of clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting facility should be confirmed in writing or verbally and includes the date of appointment, scope of privileges, restrictions, and recommendations. Affiliation verifications within the last five (5) years will be required for new appointments (2 years for reappointment). A minimum of five (5) affiliation verifications will be required if an applicant has more than five (5) affiliations. A request of the practitioners quality and performance profile/data may be accepted in lieu of a "good standing" letter for initial appointments and reappointments.

Any gaps in past five (5) years of work history, of 90 days or more will require written clarification from the provider.

If verification of an affiliation is not obtained after three attempts with the applicants assistance, including a phone call to the facility, this should be noted in the file. If verification can't be obtained due to extraordinary circumstances this needs to be documented in file and noted for Department Head/Service Chief/Division Head. The file may then move through the evaluation process without this piece of documentation.

5. Verification of Graduation from Medical/Professional School and Completion of Residencies and Fellowships

Verification of medical/professional school graduation and completion of residency and fellowship training may be obtained from the institution(s) where the training was completed, and/or an agency that is deemed a primary source verification, (such as the American Medical Association (AMA) Physician Masterfile or American Osteopathic Association (AOA) Physician Database) or Background Check for Advanced Practice Practitioners hired by HR. If unable to obtain verification from any of the above sources after three attempts, reach out to reliable secondary source such as another hospital that has a documented primary source verification of the credential.

Foreign Medical Graduates from schools of medicine other than those in the United States and Canada must present evidence of certification by the Education Commission for Foreign Medical Graduates (ECFMG) or successful completion of a fifth pathway, or, successful passing of the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS).

6. Board Certification

Board Certification is verified, through querying the ABMS on-line database (CertiFACTS), or by a letter directly from the certification board. Verification of Board Certification confirms successful completion of an approved residency program in the practitioner's specialty. Board certification is verified at time of initial appointment and also for each reappointment in order to verify current status and re-certifications, as well as participation in MOC (Maintenance of Certification).

In order to be considered for privileges at SHC and/or LPCHS all Advanced Practice Practitioners are required to have National Certification at the time of hire and maintain certification on an ongoing basis by any of the following bodies:

- American Academy of Nurse Practitioners (AANP)
- American Nurses Association – American Nurses Credentialing Center (ANCC)
- Pediatric Nursing Certification Board (PNCB)
- National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties (NCC);
- American Association of Critical-Care Nurses (AACN)
- National Commission on Certification of Physician Assistants (NCCPA)

7. Current, Adequate Malpractice Insurance

Professional Liability Insurance coverage and amounts of coverage should be confirmed directly with the carrier. If unable to receive timely we may request a copy of the Insurance Cover Sheet directly from the applicant. If the provider is insured through SUMC, a copy of the blanket policy should be accessable on MSSD TeamSite. Providers applying to the SHC/LPCHS for the first time under SUMMIT insurance can be approved contingent upon confirmation of Faculty Appointment. The provider must hold a minimum amount of coverage that covers requested privileges as determined from time to time by the SHC and LPCHS Board of Directors.

8. Professional Liability Claims History

Verification of claims history for five (5) years on new appointments and two (2) years for reappointments must be obtained from the current and/or previous carriers. If, after three attempts with the applicants assistance, including a phone call to the facility, the insurance carrier does not respond we will use the NPDB as primary source. AHPs are credentialed according to NCQA guidelines. NPDB may be used in lieu of claims history for AHPs.

Those providers who hold a full-time Faculty or Adjunct Clinical Faculty appointment with the Stanford University School of Medicine are covered under the Medical Professional Liability and General Liability plan while acting within the scope of their duties on behalf of SHC and LPCHS. A copy of this coverage statement will be accessable on MSSD TeamSite.

9. Background Checks

SHC and LPCHS engage in background checks as a verification element within the credentialing process. Any and all background reports will be stored electronically in the credential file. All adverse information found on background checks is evaluated by Department/Service/Division Chief as well as the appropriate review committee.

10. Privileging Criteria

Each applicant is expected to meet the criteria related to the privileges they are requesting on the privilege form.

11. National Practitioner Data Bank

The NPDB must be queried for all new appointments, biennially for reappointments and at time of the request for additional privileges. Each query to the NPDB is facility specific therefore there will be one (1) NPDB query for SHC and one (1) query for LPCHS if provider is on staff at both facilities. Continuous Query is utilized for all privileged members. Adverse information will be addressed on an as needed basis.

12. Medicare/Medicaid Sanctions

Sanction verifications for Medicare and Medicaid will be processed by querying the NPDB and by obtaining a Sanctions Exclusions Report (published by the OIG) via Internet site for each credentialed provider. In addition, ongoing monitoring of sanctions to Medicare and Medicaid will be done on a monthly basis by downloading the OIG Monthly Reports and verifying against current SHC/LPCHS rosters within 30 days of their release.

13. Professional References

Three professional references are requested for new applicants and two are required for packets to be complete; One peer reference for reappointments is required (Two for Advanced Practice Professionals). These references must be from individuals who have recently worked with the applicant, have directly observed his/her professional performance over a reasonable period of time, and who can and will provide reliable information regarding current clinical ability, health status, ethical character, and ability to work with others. If the applicant has recently completed a residency or fellowship within the past two years, a reference from the program director should be requested. Ratings of 2 or less and/or any adverse comments will be flagged for Service Chief and Credentials Committee review. References are not required for AHPs as per NCQA; however, up to two peer references will be collected in lieu of peer review.

14. Continuing Education

A statement documenting Continuing Education must be included with the application for appointment or reappointment, or a statement signed indicating that the practitioner has met or exceeded continuing medical education requirements for licensure.

15. Reappointment Performance Improvement Data

In addition to verifying credentials, a provider's quality data is compiled for the evaluation process. Information from the following areas may be included for consideration. Information is gathered for each facility on an ongoing basis to which the practitioner is applying. All data is then assembled and reviewed at time of reappointment and based on the timeline outlined in the Professional Practice Policy.

1. Patient
2. Medical Knowledge
3. Professionalism
4. System Based Practice
5. Interpersonal
6. Practice based medicine

16. Training Modules

See *Medical Staff and APP Educaional Requirements Policy*
http://medicalstaff.stanfordhospital.org/bylaws/policies.html

17. Health Screening

All providers are required to comply with all health screening policies set forth by regulatory standards as well as medical staff policies and procedures. Every Initial Applicant and Reappointment will have a clearance from Occupational Health Services in their file. (See Medical Staff Communicable Disease Policy and Influenza Policy)

18. NPI Number

HIPAA mandated the adoption of standard unique identifiers for health care providers ahd health plans. All initial applicants must apply or have an NPI number.

19. Opt Out Report

The Opt Out Report of Northern California is checked within 10 days of publication for any practitioners who have opted out of Medicare. When a practitioner, who is currently on our Medical Staff, is found to be on the Opt Out report using the hospital address(s) he/she will no longer be on our Health Plan contracts.

20. Additional Information

Other information as deemed necessary may also be collected and considered. Clinical Services may impose additional documentation requests, such as monitoring requirements.

21. Delegated Health Plans

Providers on our medical staff who would be considered eligible for our delegated agreements with health plans are those with a faculty appointment through the Stanford School of Medicine and any community provider who has a contract with SHC and/or LPCHS. Providers not considered for participation on our delegated agreements would be community physicians with no teaching titles or contracts. The Managed Care department has access to the information MSSD database for the purpose of providing accurate credentialing information to health plans and for the publishing of provider directories.

22. The credentialing data for all providers credentialed by MSSD is entered into the Medical Staff Office Credentialing database (MSOW). MSSD utilizes this system to maintain current credentialing and privileging information, monitor proctoring, license, DEA, and Insurance renewals, and reappointment activities. All information contained in the database is confidential and has restricted access. MSSD is responsible for ensuring that the information contained in the database is accurate and timely. The Managed Care department has access to the information MSSD database for the purpose of providing accurate credentialing information to health plans and for the publishing of provider directories.

23. All Medical Staff members are required to pay the appropriate amount of dues and application fees based on the medical staff categories outlined in the Medical Staff Bylaws. APP members do not pay dues, but may be required to pay an application fee based on employment status.

B. SHC/LPCHS Category Assessment (refer to SHC or LPCHS Bylaws)
During the processing of each reappointment, the coordinator will gather patient activity information for each facility and determine if the provider holds the appropriate status. The following guidelines will be used:

1. If a provider is currently on the Active Medical Staff, but

   - Has had less than 11 patient contacts per year at SHC and/or LPCHS during the previous two years, or
   - has had minimal or no administrative activity, or
   - is on the Active staff at another hospital, then

   The providers status may be changed to an appropriate category based on the recommendation by the Service Chief and/or Credentials Committee.

   PLEASE NOTE: Faculty providers must remain in an Active status in at least one of the facilities unless specific exception is requested by the Department Head/Service Chief/Division Head.

2. If a provider is currently Active, Courtesy or Courtesy-Admitting, and has no patient contacts or administrative activity at SHC or LPCHS during the previous two years, the provider may be voluntarily resigned from the Medical Staff(s) due to non-compliance with the Medical Staff Bylaws.

3. If a provider is currently Courtesy-Teaching and it is determined that the teaching appointment with the Stanford School of Medicine has expired the provider will be processed as a voluntarily resignation from the Medical Staff.

4. If the provider is currently in the Affiliate status, no privileges are granted. The provider will be credentialed only as part of the requirement to participate in Health Plan contracts.

If any of the above conditions are met, the coordinator will send a letter, email or fax to the provider outlining the change being recommended. The provider may inform MSSD if he/she feels the information is inaccurate. Recommendations will be forwarded to the Department Head/Service Chief/Division Head along with any additional information submitted by the provider for review and approval.

C. Expireables

The following items will be monitored as expirables. An expired certificate or license will result in a suspension of membership/privileges, or a suspension of the privilege tied to that certificate (as stated per this policy and the SHC/LPCHS Bylaws):

- CA State License
- Additional CA State License
- Furnishing License
- DEA
- Malpractice Insurance (or Academic Appointment)
- Board Certification / National Certification
- Fluoroscopy Certificate
- ACLS / APLS / ATLS / BLS / NRP / ONS / PALS (as specified by privileges)

After 90 days suspension for non renewal of license/certificate, it will result in voluntary withdrawl of membership/privileges or a voluntary withdrawl of the privilege tied to that certificate.

Practitioners will be notified by email approximately 30 days, 15 days and 5 days prior to license or certificate expiration. Departments and IDPC will be notifed 5 days prior to license or certificate expiration for practitioners in their departments.

## VII. RELATED DOCUMENTS

Stanford Health Care Medical Staff Bylaws, Rules and Regulations

Lucile Packard Children's Hospital Medical Staff Bylaws, Rules and Regulations
Credentials Policies and Procedures
Policy – AHP: Authorization for Individuals to Provide Services as Allied Health Professionals

## VIII. DOCUMENT INFORMATION

A. Legal Authority/References
1. TJC Standards
2. NCQA Standards
3. Title 22 Regulations

B. Author/Original Date
This Policy was authored by the Director, Medical Staff Services in April, 2000.

C. Gatekeeper of Original Document

The Director, Medical Staff Services (or designee), who will be responsible for initiating its review and revision. The Policy will reside in the Credentials Policy and Procedure Online Manual.

D. Distribution and Training Requirements

The distribution and training requirements for this Policy will be handled through the Credentials Department.

E. Review and Renewal Requirements

This Policy will be reviewed and/or revised every three years or as required by change of law or practice.

F. Review and Revision History

Revision –7/03, 6/05, 9/06, 6/08, 12/08, 1/09, 3/10, 11/10, 5/11, 1/12,8/14, 6/15, 6/18, 11/18
Administrative Clarifications: 10/12. 4/13

G. Local Approvals

Credentials Committee (2) –7/03, 6/05, 9/06, 2/08, 6/08, 5/11, 3/12,8/14, 6/15, 6/18. 11/18
Medical Executive Committee (2) –2003, 7/05, 10/06, 7/08, 3/09, 5/11, 4/12, 9/14, 8/15, 6/18, 12/18

H. Board Approvals

April, 2002; August, 2003, 7/05, 10/06, 7/08, 3/09, 5/11, 4/12, 9/14, 8/15, 6/18, 12/18

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SHC and LPCHS