PROCEDURE

Medical Staff Credentialing Procedure Manual

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PROCEDURE:

Yakima Valley Memorial (YVM) Medical Staff Office shall provide applications for appointment or reappointment/ credentialing or recredentialing to the Medical Staff and/or clinical privileges to all eligible applicants for evaluation by the Credentials Committee with recommendations to the Medical Executive Committee and Governing Board.

I. Medical Doctors, Osteopathic Doctors, Podiatrists, Psychologists, Dentists, and Advance Practice Professionals (APP) requesting initial appointment/or initial credentialing will be provided a Request for Application form that outlines the mandatory requirements for the status and privileges requested.

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

II. All applicants meeting the basic criteria 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. Applicants that do not meet threshold eligibility may request a waiver documenting exceptional circumstances for not meeting criteria and that they would otherwise be qualified to apply.

For purposes of this document, credentialing is defined as the process of obtaining, verifying and assessing the qualifications of Applicants who are licensed, certified or registered, to practice at YVM.

III. **Credentialing decisions**- Credentialing decisions are not based on an applicant's race, ethnic/national identity, gender, age, sexual orientation or patient type (e.g., Medicaid) in which the practitioner specializes.

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 YVM Governing Board, with the exception of Temporary/ Locum Tenens providers which are approved by the CEO on behalf of the Governing Board as noted in the Credentials Policy.

IV. **Reappointment cycle** - In compliance with The Joint Commission, reappointment/re-credentialing shall occur within a 24-month timeline.

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

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

YVM 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, YVM 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. Additional practitioner-specific information is validated during the recredentialing process. The listings on the hospital's internet Provider Directory are populated directly from the credentialing system to ensure accuracy of information.

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 YVM, 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 YVM, 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 the CMO. Requests for file review must be received by the Office of Medical Staff Services at least three (3) working days in advance.

4. The right to correct erroneous information: Applicants attest that all information submitted for the credentialing process are accurate and agrees to immediately report any changes in information. If any submitted items differ substantially from documentation disclosed throughout the verification process, the applicant will be notified in writing and asked to resolve the discrepancy. The provider may be allowed up to thirty (30) days to resolve the discrepancies, with response to the Credentials Chair.

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 of Information and Credentialing System Controls:

All activities undertaken to receive, verify, and process an Application for initial and/or renewed Membership or Clinical Privileges are part of the quality improvement and peer review processes of the Hospital and its Medical Staff and are protected as such, even if such activities occur prior to any action by the Credentials Committee with respect to the Application.

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, Medical Executive Committee, Governing Board or the MSS office. This does not preclude a practitioner from accessing his/her own credentialing information as outlined above.

Credentialing applications and supporting documentation are received via our online credentialing software portal MD-Staff and email, reviewed by the Credentialing Specialists, dated and tracked via electronic database and checklists, and stored electronically. All data and documents uploaded and entered into the credentialing software are tracked with the following elements:

- Creation date
- Last modified date
- Created by user
- Modified by user

All new applications and reapplications received after 10/1/2019 are electronically received and stored in the credentialing software. Historical paper credential files are maintained in individual folders in locked filing cabinets or specially designed areas with locked doors, with key access by Medical Staff Office personnel. 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.

Role-based security prevents unauthorized access to information and unauthorized modifications to information within the credentialing software through the grouping of users based on job description. Maintenance of credentialing software users and groups is by the Medical Staff Services Manager.

MD-Staff allows each individual user who has an account to have an individualized username and password assigned to their account. Upon hire or job reclassification, anyone with a need (e.g., PPE Specialist, Recruiter, etc.) to access MD-Staff will be granted that specific user-defined access by a member of the Medical Staff Services office. If a request for access is received from a non-traditional

user, these requests will be vetted only by the Medical Staff Services Manager for a final determination.

There are five groups/levels of access:

1) Level 1: Read Only- restricted read only access to provider demographic data without the authorization or ability to make any modification to credentialing data under any circumstance.
2) Level 2: Trainee/Intern/Volunteer- limited access to read/write for data entry purposes, applying verifications, and running reports.
3) Level 3: PPE Specialist- medium read/write access to all providers in the system for quality purposes.
4) Level 4: Medical Staff Specialist- full read/write access on all providers within the credentialing software. These individuals are directly involved in the credentialing process to credentialing and primary source verification electronic credentialing information.
5) Level 5: MS Manager- full read/write access on all providers within the corporate credentialing software. This individual is directly involved in the credentialing process to credentialing and primary source verification electronic credentialing information.

All users with access to the credentialing software must use strong passwords For maintaining confidentiality, staff shall not write down their password; but will remember it. If a user leaves the organization, the Manager of Medical Staff Services, who oversee computer security, to include credentialing database, will delete that person's user account disabling or removing passwords and access as soon as notified of termination. Additional reference to *YVM Medical Staff Services follow the overarching recommended guidelines and protocols of the Memorial Information Security Department to prevent unauthorized access, changes and/or the release of credentialing information. Supporting and referenced policy:*

MYMH Information Security Policy:
1.6 Personnel Security
a. The workforce must receive general security awareness training, to include recognizing and reporting insider threats, within 30 days of hire. Additional training on specific security procedures, if required, must be completed before access is provided to specific entity sensitive information not covered in the general security training. All security training must be reinforced at least annually and must be tracked by the entity.

Password requirements: Combination of at least 8 letters and numbers, with at least one capitalized letter and one symbol. User IDs and Passwords are unique to each other. Passwords are different for different accounts. Passwords are not to be shared. Passwords are changed when requested by staff or compromised. Users may change their password at any time but are required to change their password every 180 days. Passwords may not have the following values:

- Test, Welcome, 123
- May not include any part of the individual's name.

Medical Staff Office personnel have authority to access, modify and delete information when circumstances for modification are deemed appropriate, such as:

- Updating information during credentialing or re-credentialing
- Update information between credentialing cycles
- Update expired verifications during or between cycles
- Remove erroneous data or documentation

When e-mail confirmation for deletion/correction is available from the practitioner, the credentialing staff will attach/upload it to the file. If the application is not complete, the credentialing staff will reach out to the practitioner for additional information and modify per the direction of the practitioner.

Medical Staff Office personnel will document the date of the modification, the reason for the modification and why the modification was made. These modifications will be audited during the oversight ~~quarterly~~ review performed on a semi-annual basis. Any modification made by any individual that is not authorized to make changes would be considered a non-compliant modification. Additionally, the following are examples of non-compliant modifications:

- Modification of a primary source document.
- Deletion of a primary source document unless the document is the wrong provider saved to the incorrect file.

All documents relating to the credentialing, recredentialing, and ongoing monitoring of provider practitioner primary source verification and credentials are inaccessible to non-authorized personnel. Modifications to information in the credentialing software are automatically tracked as to the information modified, the date of modification, the user who made the modification, and what the historical/previous information was.

As the credentialing database does not automatically identify all noncompliant modifications, a semi-annual review will be conducted utilizing the following NCQA file selection standards: The Manager of Medical Staff Services, who has oversight of Medical Staff Services, will performs the semi-annual oversight audit on ~~at least 50% of the~~The file universe will include credentialing files (records) within the credentialing system, files with or without modifications. The sample that will be audited will be files with modifications whether modifications are compliant or non-compliant with our policies. When performing auditing/sampling, a minimum of "5% or 50 files" audit method will be utilized with at least 10 initial and 10 re-credentialing files reviewed. The Manager of Medical Staff Services will utilize automated reports within the system created for the purposes of analyzing data modifications to determine whether those modifications are determined to be compliant or non-compliant. Results of the audit will be completed on the audit assessment tool.

The Manager of Medical Staff Services and/or Manager of Delegated Credentialing are responsible for the completion, authentication and archival of the completed audit-assessment tool.

Semi-Annual Audit Reviews Identifies “Modifications Found Non-Compliant with Policy”

In the event unauthorized or non-compliant modifications are found as part of the semi-annual audit review, the following actions will take place:

- MSS Leadership will review non-compliant findings with their staff to review for training purposes, future assessment/trend analysis of potentially similar circumstances.
- MSS Leadership will implement additional measures of oversight for a review period of at least three months and will continue to monitor and assess compliance until it demonstrates improvement for one finding over at least three consecutive quarters.
- Additional review processes could include but not be limited to incorporating this as an additional element to be documented/tracked during standard QA reviews of completed files (initial/recredentialing).
- As needed, the Credentialing Procedure Manual will be reviewed for possible revision or edits to provided clarity surrounding unauthorized modifications.
- Upon completion of the three-month review, an additional sampling/audit will be completed to document findings.

- Upon conclusion of the successful quarterly review (3 quarters), the completed audit too will be archived to the following: the Delegated Credentialing shared drive and noted on a new section titled "Credentialing System Control Review" on our Ongoing Monitoring Log (to be completed by the Manager of Medical Staff Services and/or Delegation Manager).

The audits ensure credentialing processes are being followed. The Manager of Medical Staff Services reviews the image documents for the required elements for internet, verbal and written verifications as well as the software tracking of user modifications during the audit. Elements identified as non-compliant or incorrect are addressed immediately with the appropriate Credentialing Specialist for correction.

The Manager of Medical Staff Services will perform digital audits of provider profile modifications within the credentialing software on a ~~quarterly~~ semi-annual basis. These digital audits shall be a random sampling of provider records, the security menu for login attempts, and an ongoing review of roles and permissions by user and user group. Tracking of audit requirements can be found in the master monitoring logs. These audits and permissions shall protect provider information from unauthorized modifications. The Manager of Medical Staff Services confirms that the verifications and the associated primary source verification dates in the credentialing software correlate, while performing the ~~quarterly~~ eimi-annual audit.

Additionally, annual delegated credentialing audits are performed by the Washington Credentialing Standardization Group (WCSG) and Institute for Credentialing Excellence (ICE) for compliance with NCQA and other health plan requirements.

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

Initial Appointment / Credentialing documentation requirements	**Re-Appointment / Re-credentialing documentation requirements**
Completed YVM application, signed and dated by the applicant. Application includes the following questions, at a minimum: 1. Reasons for inability to perform the essential functions of the position. 2. Lack of present illegal drug use. 3. History of loss of license and felony convictions. 4. History of loss or limitation of privileges or disciplinary actions. 5. Current malpractice insurance coverage. 6. Current and signed attestation confirming the correctness and completeness of the application.	Completed YVM Re-Appointment / Re-credentialing application, signed and dated by the applicant. Application includes the following questions, at a minimum: 1. Reasons for inability to perform the essential functions of the position. 2. Lack of present illegal drug use. 3. History of loss of license and felony convictions. 4. History of loss or limitation of privileges or disciplinary actions. 5. Current malpractice insurance coverage. 6. Current and signed attestation confirming the correctness and completeness of the application.
Fitness for Practice Evaluation Form	
APP Supervisory Agreement (APPs only)	APP Supervisory Agreement (APPs only)

PROCEDURE

WA Medical Commission Delegation Agreement- Physician Assistants Only	Copy of Approved WMC Delegation Agreement- Physician Assistants Only
Current Professional Liability Insurance with minimum of ($1M/$3M)	
Evidence of required immunizations	
Current Curriculum Vitae (CV)	
DEA linked to a WA address or DEA coverage plan *Exceptions*: The specialties or staff categories listed below are not required to have a DEA registration - Pathology - Telemedicine - CRNA	
Specialty Board Certification or letter confirming eligibility	
Admit Plan (unless privileges include the ability to admit) *Exceptions:* The following are not required to have an admit plan, by default they utilize the Hospitalist program for patient admissions: - Anesthesia - Emergency Medicine - Pathology - Telemedicine	Admit Plan (unless privileges include the ability to admit) *Exceptions:* The following are not required to have an admit plan, by default they utilize the Hospitalist program for patient admissions: - Anesthesia - Emergency Medicine - Pathology - Telemedicine
Certifications required per privilege, (e.g. PALS, ACLS, NRP, etc.)	
Clinical Activity Logs for the past two years	Clinical Activity Logs for the past two years
Government issued photo ID	
2X2 recent photo (The photo will be included on peer reference verifications request)	

YVM requires practitioners who submit an application to meet the below criteria in order for the credentialing application to be processed:

- Current unrestricted license to practice medicine in Washington that is not subject to any restrictions, probationary terms, or conditions not generally applicable to all licenses (or evidence of application for WA license);
- Current Federal DEA and no record of past adverse license action (as applicable);
- Satisfy the requisite professional education and training requirements;
- Be Board Certified in primary area of practice, or within 7 years of completion of training program relevant to that specialty;
- Be lawfully authorized to work in the US;
- Have an appropriate coverage arrangement with other Practitioners who are qualified and have appropriate Clinical privileges for those times in which the individual will be unavailable;

- If seeking to practice as an APP, have a written agreement with a Supervising/Collaborating Practitioner;
- No record of having a license to practice revoked or suspended by any professional licensing agency in any state or any jurisdiction;
- Never having his/her prescriptive authority revoked, restricted, or suspended by a professional licensing agency in any state or other jurisdiction;
- No record of conviction of Medicare, Medicaid or insurance fraud and abuse, payment of civil money penalties for same, or exclusion from such programs;
- Never had Membership or Clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility, or health plan for reasons related to clinical competence or professional conduct;
- Have never resigned Membership or relinquished Clinical privileges during an Investigation or in exchange for not conducting an Investigation at any health care facility;
- Have never had a request for Application for Clinical privileges or Medical Staff Membership deemed ineligible for continued processing by the Hospital or any Affiliated Entity due to finding of material omission or misrepresentation nor has his/her Medical Staff Membership or Clinical privileges automatically relinquished due to such a finding;
- Have never been expelled from a post-graduate training program, nor resigned from such a program during an investigation or in exchange for the program not conducting an investigation;
- Have not, since the start of medical or professional education, been convicted of, or entered a plea of guilty or no contest to, any felony or misdemeanor related to controlled substances, illegal drugs, violent acts, sexual misconduct, moral turpitude, domestic, child or elder abuse, or Medicare, Medicaid, or other Federal or State governmental or private third-party payer fraud or program abuse, nor have been required to pay civil money penalty for any such fraud or program abuse.

If it is determined that the applicant does not satisfy one or more of the threshold eligibility criteria, he/she will be informed of the threshold eligibility criteria not satisfied. As a general rule, applications that do not satisfy one or more threshold criteria will not be processed.

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**

Initial Appointment / Credentialing requirements	**Re-Appointment / Re-credentialing requirements**
Accredited Medical/Dental/Podiatric Education (may include, but not limited to, verification through the AMA, AOA, or ADA profile, National Student Clearinghouse, 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).	

PROCEDURE

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.)	Hospital or Facility Affiliations since last appointment /credentialing with YVM. (For non-delegated telemedicine practitioners, 3-5 facilities that the practitioner has provided significant services to, will be queried.)
Professional Licensing Board Status through the AMA or individual state. In accordance with NCQA CR1A2: **For Washington State professional license, verification is obtained through the Washington State Department of Health website.** Any other states where a practitioner will provide care to members will be verified directly through the state licensing agency.	Professional Licensing Board Status through the AMA or individual state. In accordance with NCQA CR1A2 **For Washington State professional license, verification is obtained through the Washington State Department of Health website. .** Any other states where a practitioner will provide care to members will be verified directly through the state licensing agency.
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.	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.
DEA registration through the Drug Enforcement Agency or receipt of DEA coverage plan *Exceptions*: The specialties or staff categories listed below are not required to have a DEA registration (Added 2/2019): - Pathology - Telemedicine - CRNA	DEA registration through the Drug Enforcement Agency *Exceptions*: The specialties or staff categories listed below are not required to have a DEA registration (Added 2/2019): - Pathology - Telemedicine - CRNA
Professional references (as applicable)	Professional reference (as applicable)
National Practitioner Data Bank	National Practitioner Data Bank as part of continuous query
Confirmation of malpractice settlements via the carrier or the National Practitioner Databank (NPDB).	Confirmation of malpractice settlements via the carrier or the National Practitioner Databank (NPDB).
Board Certification by the ABMS, AMA, AOA, or individual Certification Boards	Board Certification by the ABMS, AMA, AOA, or individual Certification Boards
Criminal history queried through Washington State Patrol criminal background check and national/international criminal background check	
ECFMG- Education Commission for Foreign Medical Graduates (if applicable).	
Work history, including written explanation of gaps of three (3) months or more, within the last 5 years.	Work history within the last 2 years
Liability coverage history verified through the Liability Carrier, and/or the National Practitioner Data Bank	Liability coverage history verified through the Liability Carrier, face sheet and/or the National Practitioner Data Bank

Current liability coverage and limits	Current liability coverage and limits
Medicare/Medicaid Sanctions and Excluded Providers through NPDB, AMA, OIG, SAM, and/or Streamline Verify vendor	Medicare/Medicaid Sanctions and Excluded Providers through NPDB, AMA, OIG, SAM, and/or Streamline Verify vendor
State Medicaid Excluded Providers through Streamline Verify vendor and/or individual State exclusion list	State Medicaid Excluded Providers through Streamline Verify vendor and/or individual State exclusion list
SSA Death Master List through the NTIS (via Streamline Verify vendor)	SSA Death Master List through the NTIS (via Streamline Verify vendor)
NPI validation through the NPPES.	NPI validation through the NPPES.
Medicare Opt Out through CMS.data.gov	Medicare Opt Out through CMS.data.gov
Other sources, depending upon background and experience.	Other sources, depending upon background and experience.
	Quality Assurance findings regarding patterns of care relating to professional performance, judgment and clinical or technical skills.
	Compliance with all applicable Bylaws, Rules and Regulation and Policies and procedures of the Medical Staff and Hospital.
CMS Preclusion List supplied by Kaiser Foundation Health Plan of Washington or Centene Corporation. The CMS Preclusion List is a list of providers and prescribers who are precluded from receiving payment for Medicare Advantage items and services or Part D drugs furnished or prescribed to Medicare beneficiaries. Notification of any matches will be sent to the applicable health plan(s) immediately.	CMS Preclusion List supplied by Kaiser Foundation Health Plan of Washington or Centene Corporation. The CMS Preclusion List is a list of providers and prescribers who are precluded from receiving payment for Medicare Advantage items and services or Part D drugs furnished or prescribed to Medicare beneficiaries. Notification of any matches will be sent to the applicable health plan(s) immediately.

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 thirty (30) 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 Hearing and Appeals Procedures section of the Credentials Policy.

XIV. Appropriate Documentation of Credentialing Verifications

1. Credentialing verifications are tracked for completeness on a checklist system and/or verification log.
2. Verifications may be received from 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 YVM credentialing staff that received the information.
4. All verifications will be uploaded into the credentialing software, reviewed by the Credentialing Specialist, dated and tracked via the electronic database and checklists/verification logs. The verifications shall be stored electronically, with some elements still being housed in paper files within locked cabinets. Paper records are scanned into a PDF file. These files are transferred to credentialing database.

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 Credentials Committee review. Any verification or signature beyond 180 days at the time of the Credentials Committee meeting will be re-verified prior to recommendation.

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:

Individual/ Group	Time Period
Medical Staff Services (collect/summarize)	60 Days
Department Chairperson (review/recommend)	15 Days
Credentials Committee (recommend)	31 Days after the applicant has been 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

Once an Application is deemed Complete, it is expected to be processed within 120 days, unless it becomes not complete. These time periods are intended to be guidelines only and will not create any right for an Applicant to have an Application processed or to receive Notice of the outcome of the Application within these precise time periods.

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 YVM 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 the Medical Staff Bylaws, Credentials Policy, or this document.

For the purposes of this document, 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 Procedure:**

The Department Chairperson shall review the application. If deemed necessary, 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. *If an applicant's credentials file is deemed by the Department Chairperson to be free of any discrepancies, an interview is not necessary. Furthermore, interviews do not need to be performed on an APP practicing under a scope of service, or APP's without hospital privileges.*

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 means email, along with either hand delivery or US mail. In all cases where hand delivery is made as part of Special notice, the individual making the delivery must submit written confirmation of the delivery, to be included in the file.

XX. **Credentials Committee Procedure -** The Credential Committee composition, function and duties are outlined in the Medical Staff Organization Manual. The Credentials Committee shall meet monthly.

During the next Credentials Committee meeting, after receipt of the Department Chairperson's Report, the Committee will review and consider the qualifications of each Applicant to determine whether the Applicant is "otherwise qualified" for Membership and/or Clinical Privileges, taking into consideration all aspects of the Applicant's credentials except for information related to disability. 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 Recommendation**

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 Hearing and Appeal Procedures shall be initiated. *(See Credentials Policy)*

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 Directors' 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 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 Hearing and Appeals Procedures section of the Credentials Policy.

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 Hearing and Appeals Procedures section of the Credentials Policy.

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 Hearing and Appeals Procedures section of the Credentials Policy.

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 the Credentialing 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

No one will be denied Membership or Clinical Privileges on the basis of race, color, sex, gender identity, marital status, sexual orientation, creed/religion, national origin, age, patient type or disability.

PROCEDURE

Annually, the Credentials Committee signs an affirmation confirming that credentialing decision are not made based on an applicant's race, color, sex, gender identity, marital status, sexual orientation, creed/religion, national origin, disability, 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 events and complaints** The Professional Practice Evaluation (PPE) process is used when questions or concerns are raised about a practitioner's clinical performance. Referrals from a serious safety event (adverse event) or sentinel event review team involving an individual practitioner's clinical performance shall be reviewed by the Committee on Professional Enhancement (CPE). *(see Professional Practice Evaluation (PPE) Policy)* The number of cases reviewed are saved in the provider's quality file and are reviewed, at minimum, every six months as part of Ongoing Professional Practice Evaluation (OPPE) and at reappointment. All patient complaints are reviewed by a patient relations representative and are logged in the online safety event management system. Patient complaints that are referred by the patient relations representative and that require further review, as determined by the CPE Chair or Chief Medical Officer, shall trigger a review by the CPE. A history of provider complaints are evaluated as part of OPPE at least every 6 months. (*See Medical Staff OPPE 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. Action 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:

NPDB through continuous query with notification reports reviewed within 30 days of release of a new alert.
License limitations and sanction through NPDB continuous query with notification reports reviewed within 30 days of release of a new alert.
OIG, SAM/GSA monthly through Streamline Verify within 30 days of release by reporting agency, but no later than the 15th of each month.
Medicare/Medicaid sanctions and exclusions through Streamline Verify vendor within 30 days of release by reporting agency.
Medicare Opt Out Affidavit list through CMS.data.gov will be imported and reviewed monthly. Providers who appear on the Medicare Opt Out Affidavit list will be removed from the payer roster.
State Provider Termination and Exclusion through Streamline Verify vendor or State, monthly, or with 30 days of release.
SSA Death Master List through the NTIS via Streamline Verify vendor on Initial credentialing and re-credentialing.
Adverse Events or Complaints through CPE, OPPE, reappointment and the Safety Event Reporting system.
CMS Preclusion List supplied by Kaiser Foundation Health Plan of Washington or Centene Corporation, verified monthly upon receipt. Notification of any matches will be sent to the applicable health plan(s) immediately.

XXVIII. Process for Sub-Delegating Credentialing and Re-credentialing

1. YVM may delegate credentialing and recredentialing activities to groups that meet YVM's standard requirements as outlined in this Credentialing Manual.
2. All agreements will be mutually approved by YVM and the delegate.
3. YVM retains the right to limit or revoke any and all delegated credentialing activities when a delegate fails to meet YVM's requirements.
4. YVM retains the right to approve, suspend and terminate delegated practitioners or providers.
5. YVM will, at least annually, audit the delegate to ensure all YVM 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 YVM's standards for credentialing upon YVM'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. YVM remains responsible for querying the NPDB.

XXIX. Office site visits - The Health Plans which delegate their credentialing to YVM'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 YVM designated employee when complaints dictate. 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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Governing Department:	Medical Staff Services		
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Revised By:	Josephine Johnston, CPCS, Credentialing Specialist	**Date:**	10/6/2022
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Approved By:	Credentials Committee	**Date:**	11/8/2022 12/12/2023
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NOTE:
11/8/2022 – Revised to incorporate NCQA CR 1 C, Factors 1-5.
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