Virginia Mason Franciscan Health

CREDENTIALING PROGRAM
OF THE
MEDICAL STAFF
OF

VIRGINIA MASON MEDICAL CENTER

Board Approval: March 28, 2023

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Virginia Mason Medical Center
Credentialing Program Description

I. PURPOSE

Virginia Mason Medical Center's (VMMC) vision is to be the Quality Leader and transform health care. VMMC recognizes that a robust provider credentialing program is essential to delivery of high-quality medical care to all of our patients. At a minimum, Virginia Mason Medical Center shall meet all Joint Commission, National Committee on Quality Assurance (NCQA), and any other applicable credentialing requirements.

II. SCOPE

The Credentialing Program process applies to physicians and independent healthcare professionals providing care at VMMC. Section III, Definitions (below), defines these professionals within two categories: privileged professionals including Physicians, Privileged Allied Health Professionals and other staff members (Dentists); and Nonprivileged Allied Health Professionals.

In its decisions regarding credentialing, appointment and privileges, VMMC does not discriminate on the basis of age, sex, race, creed, color, disability, veteran's status, national origin, sexual orientation, the types of procedures or patients (e.g. Medicaid) in which the practitioner specializes, or any other basis prohibited by law.

III. DEFINITIONS

The following definitions apply to VMMC's Credentialing Program Description and Credentialing Policies and Procedures:

- **Applicant:** A Physician, Dentist, Privileged AHP, or Nonprivileged AHP who submits an initial application for, as appropriate, credentialing, appointment and clinical privileges to practice at VMMC.
- **Core Privileges:** Those clinical activities within a specialty or subspecialty that any appropriately trained Physician would be competent to perform.
- **Credentialing:** The process of obtaining, verifying and assessing the qualifications of practitioners to care for or provide services at Virginia Mason Medical Center.
- **Dentist (DDS or DMD):** a Doctor of Dental Surgery or Doctor of Medical Dentistry. These practitioners may be granted clinical privileges.
- **FPPE:** Focused Professional Practice Evaluation is required by The Joint Commission. It is a time limited process used to evaluate and validate Physician, Dentist, and Privileged AHP competence with respect to the specific privileges requested. The process is implemented for all initially requested privileges or when a question arises regarding a currently privileged practitioner's ability to provide safe, quality patient care.
- **Nonprivileged Allied Health Professional or Nonprivileged AHP:** An allied health professional who is credentialed but not granted clinical privileges at VMMC. This includes a Physical Therapist (PT), Physical Therapy Assistant (PTA), Occupational Therapist (OT), Audiologist (AuD), Speech & Language Therapist (SLP), Dietitian (RD), Pharmacist (PharmD or RPh), Genetic Counselor, or Massage Therapist (LMP).
- **OPPE:** Ongoing Professional Practice Evaluation is required by The Joint Commission and is a process designed to continuously evaluate clinical competency, and to identify trends that impact quality of care and patient safety. The information gathered is factored into decisions

to maintain, revise, or revoke existing privileges; or refer for focused professional practice evaluation (FPPE).

- **Physician:** A Doctor of Medicine (MD), Doctor of Osteopathy (DO), or Doctor of Podiatric Medicine (DPM). These practitioners are appointed to the VMMC Medical Staff and granted clinical privileges.
- **Primary Source Verification (PSV):** Verification of an individual practitioner's reported qualifications by the original source, an approved agent of the original source, or the accrediting agency accepted source. Methods for conducting primary source verification of credentials include direct correspondence, documented telephone verification, or secure electronic verification from the original qualification source.
- **Privileged Allied Health Professional or Privileged AHP:** Any person other than a Physician, or dentist who is qualified by education, training and experience to provide patient services within the scope of his or her qualifications, and who is individually granted clinical privileges in accordance with the VMMC Medical Staff Bylaws. This includes but is not limited to an acupuncturist(LAc), advanced registered nurse practitioner (ARNP), cardiopulmonary perfusionist (CCP), certified registered nurse anesthetist (CRNA), clinical nurse specialist (CNS), clinical pharmacist (PharmD), clinical psychologist (PhD or PsyD), dependent surgical assistant (RN, RNFA), doctor of naturopathic medicine (ND), optometrist (OD), orthotist (CPO), licensed social worker (LICSW), physician assistant (PA), physician assistant-certified (PA-C), and prosthetist (CPO).
- **Privileging:** The process whereby the specific scope and content of patient care services are authorized for a health care practitioner by VMMC based on evaluation of the individual's credentials and performance.
- **Should/May:** Indicates that staff may use his/her own judgment regarding compliance with the actions described or defined.
- **Will:** Indicates that staff must comply with the action(s) described or defined

IV. Rights of Applicants:

A. Review of Application Information

Upon receipt of a completed application from any Applicant (Physicians, Dentists, Privileged AHP and Nonprivileged AHP), the Medical Staff Services Department will contact the Applicant and acknowledge receipt of the application. The Medical Staff Services Department will inform the Applicant of their right to be informed of the status of their application upon request; the information they are allowed to share with the practitioner; and the process for responding to requests for application status.

The Applicant's rights include:

- The ability to request information concerning the status of his or her application.
- The right to review information that was obtained by VMMC including information from an outside primary source that was used to evaluate the credentialing application except references, recommendations or other peer review protected information.

If, as part of the review process, the Applicant finds information that he/she believes to be incorrect, the Applicant will have 10 working days to submit written documentation in support of his/her position to Medical Staff Services. Medical Staff Services staff will respond to the Applicant promptly, in writing. Medical Staff Services documents receipt of corrected information in the practitioner's credentialing file.

B. **Correction of Erroneous Information/Process for Notification of Applicant** In the event that the credentialing information obtained from other sources varies substantially from that provided by the Applicant, the Medical Staff Services Department will contact the Applicant. A response from the Applicant will be requested within the time period stated in the request for information letter or in a documented telephone conversation.

V. Committees

A. Board of Directors

The Board of Directors is responsible for: 1) initial appointments and reappointments to the Hospital Medical Staff; 2) the granting of initial, renewed, or revised clinical privileges; and 3) the restriction, modification, or revocation of these appointments or privileges. The Board of Directors has delegated its authority to act under this provision to the Board Officer's Committee to expedite the necessary Board actions under this Article. This committee, consisting of at least two (2) Board officers, may only review applications that meet, as applicable, the criteria set forth in this Credentialing Program Description; the tables appended to the Initial Credentialing Requirements Procedure Description; and the Recredentialing and Reappointments Procedure Description.

The Board shall base any action under this provision in part on the recommendations of the Medical Executive Committee or Credentials Committee, and any decision made by an appointed committee to which the Board has delegated credentialing authority.

B. Medical Executive Committee

The Medical Executive Committee is the Executive Committee of the Medical Staff. Article XIII of the Medical Staff Bylaws provides a full description of Medical Executive Committee membership and duties.

C. Credentials Committee (Physicians, Dentists, Privileged AHP)

1. **Purpose**: The Credentials Committee oversees the review of new Physician, Dentist, and Privileged AHP Applicants and makes recommendations regarding the granting of clinical privileges. The Committee makes recommendations to the Medical Executive Committee for all initial credentialing, appointment and privileging decisions as well as recredentialing, reappointment and renewal of clinical privileges. FPPE and OPPE review are a required part of the process as outlined below.

2. **Membership:** The Credentials Committee includes a minimum of six members of the Active Medical Staff and at least one Allied Health Professional to ensure broad medical department representation. A designated VMMC Vice President shall be a member; and either the chair or deputy chair of the Quality Assessment Committee shall be a member. The Chair of the Credentials Committee is a physician appointed by the Chief of Staff, subject to approval by VMMC's Chief Executive Officer.

3. **Governance:** The Credentials Committee meets with a quorum present on a monthly basis (or as more frequently required). Fifty percent (50%) of the total voting membership of the Credentials Committee constitutes a quorum. The act of a majority of voting members at which a quorum is present shall be an act of the Credentials Committee.

The Credentials Committee reviews the credentials of practitioners who do not meet VMMC's criteria; gives thoughtful consideration to credentialing information; and documents discussion about credentialing in meeting minutes.

Credentialing files that meet VMMC's criteria ("clean files") are reviewed and approved by the Section Head or Department Chief and then presented to the Credentials Committee on the consent agenda for approval.

The Chair of the Credentials Committee has direct oversight of the Credentials Committee's decisions and process. The Chair attends the Medical Executive Committee and presents the recommendations of the Credentials Committee to the Medical Executive Committee. The Chief of Staff reports the Credentials Committee's recommendations to the VMMC Board Officer's Committee.

4. **Standard Process Review:** The Credentials Committee will review its standard process annually to evaluate and confirm, for the preceding time period, that its review of each provider appropriately followed designated screening criteria for determining quality and liability claims experience.

5. **Confidentiality:** All members of the Credentials Committee sign a Credentials Committee Participation Agreement annually in which the member agrees to the nondiscrimination provisions listed above and agrees to maintain the confidentiality of all files to which he/she may have access during the course of their committee participation.

D. Sub-Committee: Interdisciplinary Credentials Committee (Nonprivileged AHP)

1. **Purpose:** The Interdisciplinary Credentials Committee reviews and approves the credentials of Nonprivileged AHP.

2. **Membership**: The membership includes a representative of each designated specialty.

3. **Governance**: The Medical Staff Services Division Manager, or designee, shall serve as the Chairperson of the Interdisciplinary Credentials Committee. The Interdisciplinary Credentials Committee shall meet bi-weekly or as needed and report its activities on a monthly basis to the Credentials Committee.

VI. Credentialing (Physicians, DDS, Privileged AHP)

A. Initial Credentialing/Appointment/Privileges:

Initial credentialing, appointment and privileging decisions (as appropriate) for Physicians, Dentists and Privileged AHP are based on several factors including, but not limited to, education, licensure, training, experience, competence, and ability to perform the requested privileges. All Physicians are required to be Board certified or Board eligible in order to be credentialed/appointed at VMMC. There are established core privileges for each medical specialty. Physicians have the option to apply for specialty privileges if established criteria are met and evidence exists to support. Physicians, Dentists and Privileged AHP are required to produce evidence of competency in requested privileges. Examples of evidence includes procedure logs and required continuing medical education credits.

The initial credentialing process starts when a Physician, Dentist, or Privileged AHP submits a complete application form, supporting documentation and a credentialing fee (if applicable) to the Medical Staff Services Department. Medical Staff Services staff verifies receipt of the application materials and primary source verified documents. The Section Head and/or Department Chief reviews the file and advances his/her recommendation to the Credentials Committee for further review and approval. The recommendation of the Credentials Committee is forwarded to the Medical Executive Committee, which reviews and advances recommendations for final approval by the Board of Directors or its delegated credentialing authority. Following approval by the Board (or its delegated authority) the Physician, Dentist, or Privileged AHP is notified in writing of credentialing and privileges decisions within ten (10) calendar days of the Board's decision.

B. **Focused Professional Practice Evaluation (FPPE):**

Each Physician, Dentist, and Privileged AHP will be subject to a period of FPPE under the following circumstances:

- Any time privileges are initially granted; or
- Any time a question arises regarding a currently privileged practitioner's ability to provide safe, quality patient care. This includes questions that arise as part of or outside of the Ongoing Professional Practice Evaluation (OPPE) process.

Medical Staff Services processes FPPE based on current policy and/or approved desktop procedures using the approved evaluation forms.

C. **Ongoing Professional Practice Evaluation (OPPE):**

In compliance with The Joint Commission accreditation requirements for ongoing professional practice evaluation, each Physician, Dentist, and Privileged AHP will be reviewed by the Section Head and/or Department Chief every twelve (12) months using the current OPPE policy and / or approved desktop procedure and using the approved evaluation forms. OPPE facilitates early intervention, feedback and response when practice trends raise concerns regarding quality and patient safety.

D. **Recredentialing/Reappointment (Including Renewal of Privileges):** Recredentialing, reappointment and privileges renewal (as appropriate) for each Physician, Dentist, and Privileged AHP will occur periodically, not to exceed every three (3) years Credentials files will be maintained for each Physician, Dentist, and Privileged AHP. Files will contain information such as licensure, training, continuing education, peer review and professional liability claims data, and quality information developed as part of VMMC's Coordinated Quality Improvement Plan, OPPE, and will, therefore, be protected from discovery by statute.

Each Physician, Dentist, and Privileged AHP submits a completed application, provides supporting documents and pays a credentialing fee (if applicable) to the Medical Staff Services Department. The Medical Staff Services Department verifies receipt of application materials and collects quality data, most recent OPPE form, professional liability claims data and other quality metrics as deemed appropriate.

Upon verification of completed applications, the Section Head and/or Department Chief reviews files and advances their recommendations to the Credentials Committee for further review and recommendation. The recommendation of the Credentials Committee is forwarded to the Medical Executive Committee, which reviews and advances

recommendations for final approval to the Board of Directors or its delegated credentialing authority. Following approval by the Board (or the designated authority) the Physician, Dentist, or Privileged AHP is notified within ten (10) calendar days in writing of decisions regarding the reappointment period (as appropriate) and privileges granted.

E. Inpatient Coverage Plan – ARNPs & PA-Cs (functioning as PCPs) (NCQA Requirement):
ARNPs and PA-Cs do not have admitting privileges at VMMC. In the event that a primary care patient of either an ARNP or PA-C requires admission, inpatient coverage arrangements will be made such that the patient will be admitted and followed by the Hospitalist Service, the physician(s) within the team, or the on-call physician.

F. Denial/Termination:
Notwithstanding the process set forth in this Section VI, if at any point a Physician, Dentist, or Privileged AHP fails to meet the standards of care for credentialing or re-credentialing, the Medical Executive Committee may recommend denial or termination of the Physician, Dentist, or Privileged AHP's application. The Physician, Dentist, and Privileged AHP is notified by first class mail within ten (10) business days of the denial or termination of privileges and the notification will include the reason(s) for the denial/termination and of their rights to appeal, subject to Medical Staff Bylaw requirements. The Legal Department will be consulted for guidance in writing the letter to be sent to the Applicant.

Denials and terminations are tracked annually by the Medical Staff Office and monitored to ensure decisions are conducted in a nondiscriminatory manner.

VII. Credentialing of Nonprivileged AHP

Initial credentialing decisions for Nonprivileged AHP are based on several factors including, but not limited to, education, licensure, and experience. The initial credentialing process starts when the Nonprivileged AHP submits a complete application form, supporting documentation and a credentialing fee (if applicable) to the Medical Staff Services Department. The Medical Staff Services staff verifies receipt of the application materials and primary source verifies the information contained.. The Interdisciplinary Credentials Committee (IDC) reviews and makes recommendation on the credentials of the Nonprivileged AHPs. The IDC will review and vote on clean files via electronic meetings. The IDC will meet in person to review and discuss files with red flags. Notification of the Nonprivileged AHP approvals (or denials) is forwarded to the Credentials Committee, for informational purposes and no further action is required.

The Nonprivileged AHP is notified in writing within ten (10) calendar days of decisions regarding initial credentialing and reappointment.

Denials and terminations are tracked annually by the Medical Staff Office and monitored to ensure decisions are conducted in a nondiscriminatory manner. Each committee member signs a participation agreement annually to conduct decisions in a nondiscriminatory manner.

VIII. Ongoing Monitoring of Criminal Background Activity, Sanctions and Complaints Physicians, Dentists, Privileged AHP and Nonprivileged AHP

A. Between cycles of recredentialing and reappointment Physicians, Dentists, Privileged AHP and Nonprivileged AHP are monitored for criminal background activity, sanctions, limitations on licensure, and complaints as follows and applicable:

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1. **CMS Preclusions Listing:** On a monthly basis and within thirty calendar days of release of information, CMS Preclusions Listing are reviewed and are supplied by delegated health plans. The results of the review are logged in the Ongoing Monitor log and include the date of the Preclusion report, date of review, findings and initials of the reviewer.

2. **Criminal Background Activity:** Following initial credentialing, a criminal background check will be conducted every two years using the Washington State Patrol electronic site.
   - **Non-VMMC Employed Providers** - Results are reviewed and verified and a copy of the results is date stamped, initialed and filed in the providers' credentialing folder in the Medical Staff Services Department.
   - **VMMC Employed Providers** - Results will be tracked and maintained by VMMC Human Resources Department

3. **Medicare/Medicaid Sanctions:** Monthly, Medicare/Medicaid sanctions are reviewed through the General Services Administration (GSA) Excluded Parties List Systems (EPLS) via the System for Award Management (SAM) website and the Office of Inspector General (OIG) website or via an online database query. Results are verified and logged in the Ongoing Monitor log and include the date of the report, date of review, findings and initials of the reviewer.

4. **Medicare Participation Requirements**: All Physicians shall execute the Physician Acknowledgement Statement (Medicare and CHAMPUS Prospective Payment Systems). VMMC does not contract with any Physicians, Dentists, Privileged AHP or Nonprivileged AHP who have opted out of participation in Medicare.

5. **Medicare Opt-Out:** On a monthly basis and within thirty calendar days of release of information, Medicare Opt Out reports are reviewed through an online database query. The results of the review are logged in the Ongoing Monitor log and include the date of the report, date of review, findings and initials of the reviewer.

6. **Sanctions and limitations on licensure:** VMMC uses NPDB for continuous query of practitioners. Reports from NPDB are sent to the Division Manager, Medical Staff Services who reports these to the Credentials Committee, when applicable.

7. **Patient Complaints:** Physician, Dentist, Privileged AHP and Non-Privileged AHP patient complaints are handled both on the department level and by the Patient Relations Department. The Patient Relations Department records and follows up on patient complaints.

   Complaints are routinely received, acknowledged, investigated and responded to within 30 days. Patient relations records complaints into a database. Medical staff services reviews the database for each physician, dentist, privileged AHP and nonprivileged AHP every 6 months for OPPE and recredentialing/reappointment . These reports are reviewed and filed in the healthcare providers Quality file in the Patient Safety Department. The Patient Relations Department routinely advises the Chair of the Quality Assessment

Committee, accountable Section Head and/or Department Chief of significant patient relations concerns or identified trends for further review, evaluation, corrective action and follow-up as appropriate. In cases where the circumstances appear to pose a risk to patient care and safety the Patient Safety Alert process will be initiated.

8. **Adverse Events:** Adverse events are handled at the department level by the Medical Staff department(s) involved and by the Patient Safety Office per the organization's Patient Safety Alert (PSA) process. Documentation related to PSAs, including adverse events, is maintained in the Patient Safety Office. PSA investigations concentrate on systems and process concerns. When there are questions around a provider's individual performance, a standard of care (SOC) assessment by the provider's peers is initiated. SOC reviews are saved in the provider's quality file and are reviewed every six months as part OPPE and reappointment processes

B. **Procedure** When evidence of criminal background activity, sanctions and limitations on Physician, Dentist, or Privileged AHP licensure, or negative trends in patient complaint data and/or Standard of Care results as identified on the Quality Assessment Form are obtained, the Medical Staff Services Department notifies the Chair of the Credentials Committee and/or the Chair of the Quality Assessment Committee for evaluation and recommendation.

Procedures to address the foregoing developments as well as suspensions and requests for corrective action are also addressed in the Medical Staff Bylaws. In cases where it is determined that the circumstances may pose an immediate risk to patient care the Patient Safety Alert process will be initiated.

Evidence of criminal background activity, sanctions and limitations on Nonprivileged AHP is referred to Human Resources.

C. **Reporting Requirements:** When an Adverse Recommendation (as defined in the Medical Staff Bylaws) has been made, a first class letter is sent to the Physician, Dentist, or Privileged AHP describing the Adverse Recommendation made, and notifying the Physician, Dentist, or Privileged AHP of his/her right to a Fair Hearing, to the extent applicable as outlined in the Medical Staff Bylaws. The Physician, Dentist, or Privileged AHP is given 30 days following receipt of the above notice to request a Fair Hearing. If requested, the Hearing and Review Procedure located in the Medical Staff Bylaws will be followed.

IX. Site Visits

All VMMC patient care facilities are accredited by The Joint Commission (TJC). Survey of VMMC ambulatory sites and clinics and offices is conducted on a routine basis. Reports relating to survey results are presented to the VMMC Core Safety Committee.

X. Delegation

VMMC may delegate certain credentialing functions with oversight when a strategic partnership is formed and requires a mutual agreement with the delegate in compliance with applicable law, regulation, and government mandates.

XI. Credentials System Controls Policy

To ensure appropriate systems controls are in place to ensure the security and confidentiality of credentials information.

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A. Primary source verification (PSV):

1. **Received:** Primary source verification may be received by sources as outlined in the Addendum and may be received in electronic or hard copy format.

2. **Stored:** Virginia Mason Medical Center (VMMC) utilizes an electronic, paperless credentialing system to process and maintain credentialing information in a secure, confidential manner. All hard copy credentialing documentation (i.e. fax, mail, etc.) received by medical staff services will be scanned to electronic image and stored in the secure credentialing system and hard copies will be discarded into the secure document shredding bin per organizational policy.

   Credentials files maintained prior to the implementation of electronic credentialing processes, that had not previously terminated privileges/membership at VMMC, also known as "Legacy Files", are maintained in paper format in the Medical Staff Services Department of VMMC, if they have not yet been converted to electronic format in the secure credentialing system, then shredded utilizing Virginia Mason's secure paper shredding process.

   Credentials files of providers who had previously terminated their relationship with VMMC are in off-site storage through a secure and compliant vendor. All records are maintained per the VMMC Retention of Nonmedical Records policy.

3. **Dated:** Documentation received will be acknowledged by Medical Staff Services staff by dating the document with the received/reviewed date and indicating the staff members initials and/or name and saved to the electronic credentials file and database

B. Security Controls

1. Physical Location: The Medical Staff Services department is accessible via passcode protected door locks. Only VMMC employees co-located within Quality & Safety with integrated workflows have access via passcode to the physical environment of Medical Staff Services department. Any other individual requiring entry to the physical environment will be admitted by a staff member on a case by case basis.

   Retained paper credentials files are stored in locked, secured file cabinets in the Medical Staff Services Department. These cabinets always remain locked, with the keys available maintained by an assigned individual. A log will be maintained with the keys in the documenting access, and at a minimum will record Date, Time, File Accessed, Reason for Access, and Person Accessing.

   Archived paper files of providers no longer active with Virginia Mason Medical Center are held at an off-site secure location utilizing contracted record keeping company. All paper files are maintained according to the VMMC Retention of Nonmedical Records policy.

2. Electronic credentials documents are maintained in a secure database and/or electronic document drive. Access is password protected, utilizing Virginia Mason Information Systems Network User ID and Password. All users are subject to the Virginia Mason Responsible Use of Systems and Electronic Communications policy, and passwords are

regularly changed, as well as access terminated upon departure in accordance to Virginia Mason Information System and Data Security standards.

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 security access is maintained by the Director, Medical Staff Services or designee. The secure credentials database tracks document and information creation date, modification date, and user information.

C. Tracking Credentialing Data Modifications

1. **Credentialing applications and supporting documents received from a provider are never modified.** The Provider may make corrections to an application, or supply additional supporting documentation, but the Medical Staff Personnel will never modify the original documents and will keep the document history together.

2. **PSV is never modified.** In the unlikely event a corrected PSV is received, the corrected PSV would be attached to and saved with the original document.

3. **Authorization to Modify Credentialing Information.** Medical Staff Personnel are assigned user roles based on areas of responsibility as defined in their job description.:

Title	Role
Division Manager, Medical Staff Services	Appropriate modifications list
Medical Staff Coordinator	Appropriate modifications list
Supervisor, Credentialing Office	Appropriate modifications list
Credentialing Specialist	Appropriate modifications list

Appropriate modifications to credentialing information include, but are not limited to:

- Changes/updates to Entity specific demographic and contract data;
- Updates to expired licenses, registration or certifications;
- Changes/updates to practice or billing location demographic data;
- Changes/updates to education, training, specialty or privileges;
- Updating credentialing approval dates following recredentialing;
- To correct data entry errors; and/or
- To move documents appended to the incorrect Provider record.

Inappropriate Modifications to credentialing information include, but are not limited to:

- Altering credentialing approval dates outside the recredentialing approval process;
- Altering dates on credentialing applications or supporting documents;
- Altering dates or information on received PSV; and/or
- Whiting out dates or signatures on hard copy documents (applicable only if hard copy documents are utilized and archived).

Each user role is assigned specific read/write credentialing system access as needed to perform their duties. Assigned read/write system access may include modifying and deleting credentialing information.

4. **Deletion of credentials documents** are performed by the Division Manager, Medical Staff Services or their designee. Request for deletion of documentation should be received by the Director or designee in writing, noting the document to be deleted, and the reason for deletion. Deletion of documentation should only be utilized to remove erroneous data or documentation. The Director, Medical Staff Services shall validate the reason for deletion prior to deleting any documentation.

D. Credentialing System Oversight

1. **Audit:** On an annual basis, the Division Manager Medical Staff Services, or their designee, will conduct an audit of system controls and credentialing files approved within the previous 12-month period to confirm no Inappropriate Modifications occurred.
   The audits are as follows:
   - **a.** Log documenting key access to the physical cabinets maintaining the legacy files will be audited by the Division Manager, Medical Staff Services or designee for review of access, and appropriateness of access to credentials files.
   - **b.** Credentialed provider electronic files will be selected quarterly at random, for a total of 5% or 50 files annually, whichever is less and will be reviewed in the credentialing database by the Division Manager, Medical Staff Services or designee. This review will include review of all documents and data, as well as electronic audit log of creation/modification/deletion of information and documentation.
   - **c.** Division Manager, Medical Staff Services or designee will review each user profile in the electronic credentials database for appropriateness of access and security level based on the user's current status, role, and job function.

2. **Findings**
   - **a.** The Division Manager, Medical Staff Services or their designee will summarize and present the audit findings to the VMMC Credentials Committee.
   - **b.** Any evidence of Inappropriate Modifications will be analyzed to determine the root cause and identify any potential system deficiencies and a corrective action plan identified to correct said deficiencies.
   - **c.** There is no acceptable threshold or benchmark for Inappropriate Modifications, a single finding will trigger a quarterly monitoring process to assess the effectiveness of its actions on all findings until it demonstrates improvement of at least one finding over three consecutive quarters.
   - **d.** Inappropriate Modifications attributed to a specific Medical Staff Personnel will be reviewed and addressed in accordance with applicable HR policies and procedures.

XII. Resignation/Termination Reinstatement

Resignations/terminations that have been reviewed and approved by the board that wish to reinstate their credentialing/privileging must complete the initial application process.

XIII. Credentialing Criteria

A. All Physicians, Dentists, Privileged AHP and Nonprivileged AHP must meet and maintain applicable VMMC Credentialing Criteria and Standards in order to be accepted or continue

participating as a healthcare provider. Both initial credentialing and subsequent reappointment will include verification of:

1. Current Washington State licensure
2. A valid DEA or CDS certificate, if applicable
3. Education and training (Initial only)
4. Board Certifications
5. Review of disciplinary actions or sanctions taken by any state or governmental professional body
6. Professional work history
7. Current Professional liability insurance coverage
8. Professional liability claims history
9. Physical and mental capacity to perform procedures and render essential functions of the position
10. Background Check
11. Competence in delivering healthcare services
12. Attestation confirming correctness and completeness of the applications

B. A formal peer review will precede all credentialing, reappointment and privilege renewal for Physicians, Dentists and Privileged AHP. Components of such peer review will include:

1. Patient complaint information
2. National Practitioner Data Bank Reports
3. Peer review surveys
4. Other peer review metrics as determined to be appropriate

XIV. Confidentiality

Information and reports generated for or from credentialing activities shall be treated as confidential and shall be protected to the fullest extent allowed under applicable laws and statutes. Minutes of meetings, findings and recommendations shall be kept in a confidential and secure manner. Credentialing records will be made available only to those who have a right to such information within the scope of their authority or as required by law.

XV. Legal Compliance: Health Insurance Portability and Accountability Act (HIPAA)

All VMMC providers are expected to abide by applicable Federal and Washington State Law, as well as VMMC policies and procedures, including, but not limited to those laws, policies, and procedures, which pertain to the privacy and security of health information including federal privacy and security standards issued pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") and codified at 45 C.F.R. parts 160 through 164, as modified by the Health Information Technology for Economic and Clinical Health ("HITECH") Act codified at 42 U.S.C. §§ 17921–17954 (collectively referred to as the "HIPAA Standards"). If a Physician, Dentist, Privileged AHP or Nonprivileged AHP is obligated to maintain professional certification through the submission of patient logs listing procedures performed or other personal healthcare information, he/she is obligated to ensure that all information released is in accordance with HIPAA Standards.

XVI. Credentialing Program Review

The Credentialing Policies and Procedures are reviewed at least annually and revised as necessary by the Credentials Committee, Medical Executive Committee and approved by the Board of Directors to assure ongoing, comprehensive and effective functioning of the credentialing process.

Approved by:	**Date:**

Credentials Committee	03/02/2023
Medical Executive Committee	03/07/2023
Board of Directors	03/28/2023

ATTACHMENT A

Primary Source Verifications			
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified with: agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**
Licensure status including Sanctions/Limitations	• State Board responsible for issuing licensure (i.e. Medical, Osteopathic, Nursing, Physical Therapy, etc.) • NPDB • AMA profile for MD/DO/PA	• Screen print from officially recognized State Board Website. • Telephone/written verification from State Board. • Electronic query to NPDB website for sanctions/limitations • AMA website query for • sanctions/limitations	• Copy of verification in the file. • Copy of license desirable, but not required. • Copy of NPDB results in file. • Copy of AMA query results in file
Hospital privileges	Directly with hospital	Directly with the hospital or through review of the hospital credentialing database as applicable.	• Screen print in file. • Documentation via verification log
Drug Enforcement Administration (DEA)	DEA certificate	• DEA Database verification • For Physicians and PA's, AMA website query. • Copy of DEA certificate	• Screen print in file • Copy of AMA query results in file • Visual inspection, copy of DEA certificate in file.
Board Certification	• Any form of the official • American Board of Medical Specialists (ABMS) Directory including Official Display Agent entities. • Directly with the certifying Board. • American Osteopathic • Association (AOA).	• Screen print/copy of page from ABMS/Official Display Agent • information. • Telephone verification directly from specialty Board. • Letter on letterhead from specialty Board • • AOA Website verification.	• Copy of verification in file. • Copy of Board Certificate desirable, but not required.
Peer References (Required only for Hospital privileges)	Directly with Peer	Letter	Letter in file
ECFMG	Directly with ECFMG	Screen print/copy of web verification	Verification in file.
Military Service	• Moonlighting letter – Active Duty only • DD214 – Former military	• Letter on letterhead from Command. • Copy of form	• Copy of verification in file. • Copy of form in file.
Advanced Registered Nurse Practitioner (ARNP) Boards	• Directly with • AANP • ANCC • NCC • Any other Advanced Practice Nursing Certification Board(s)	• Internet verification directly from Board. • Telephone/written verification from Board	• Copy of verification in file. • Copy of Certificate, desirable, but not required.

Physician Assistants NCCPA Certification.	Directly with National Commission on Certification of Physician Assistants.	• Internet verification directly from NCCPA. • Telephonic/written verification from NCCPA	• Copy of verification in file. • Copy of Certificate desirable, but not required.

Primary Source Verifications			
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified with: agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**
Certified Nurse Midwife	• American Midwifery • Certification Board (Formerly American College of Nurse Midwives or ACNM Certification Council). • State licensure Board	• Internet verification directly from AMCB and State licensure Board (RN license) • Telephone/written verification from AMCB and state licensure Board (RN license)	• Copy of verifications in file. • Copy of Certificate and License desirable, but not required.
Education Verification	• Directly with educational facility(ies). • AMA profile for MD/DO/PA • American Osteopathic • Association (AOA) profile.	• Telephone/written/organization's official internet website verification from educational facility. • AMA website query. • AOA website query	• Copy of verification in file. • Copy of AMA query • results in file. • Copy of AOA query results in file.
Malpractice insurance coverage	• Malpractice Carrier	• Malpractice Insurance Face sheet Telephone or written verification direct from malpractice insurance carrier if applicable	• Copy of face sheet in file. • Copy of verification in file.
Professional liability claims history	• National Practitioner Data Bank (NPDB) • Directly from malpractice carrier.	• Written statement from the provider of previous five (5) years (or since last credentialed by FMG) professional liability claims history • Electronic query of NPDB • Directly with malpractice carrier	• Attestation and statement(s) from application • NPDB report results • Response from malpractice carrier.
Medicare Sanctions	• NPDB • Office of Inspector General (OIG)	• OIG printout from website • OIG telephone or written verification. • Screen print from electronic query of NPDB.	• Printout from OIG website or another vendor providing same verification or written verification. • NPDB report results
System for Award Management (SAM)	• Online database query	• SAM printout from website.	• Printout from SAM website or other vendor providing same verification. May contain handwritten notes as the system evolves to include names in results or not.
CMS Opt Out	• Online national database query	• Opt Out printout from website.	• Printout from Opt Out website or other vendor providing same verification.
CMS Preclusion List	• CMS Preclusion list	• CMS Preclusion list from Health Plan or other vendor providing same verification.	• Checklist notation

Primary Source Verifications			
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified with: agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**
NPI Verification	• NPPES website • Other internet sources approved by NPPES to provide NPI information	Printout from website(s)	Printout from website in file
Physician Assistant Delegation Agreement	DOH website	• Copy of agreement with Approval stamp • Copy of submittal confirmation from DOH website	• Copy of document in file • Copy of document in file