




**CREDENTIALING, RECREDENTIALING,  
AND PRIVILEGING  
POLICY & PROCEDURE MANUAL**

**2018**

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## Office of Medical Staff Services Manual

	Policy Name	<b>Office of Medical Staff Services Staff Directory &amp; General Information</b>
	Policy Number	<b>OMSS - General</b>
	Date this Version Effective	<b><i>January 2018</i></b>
	Responsible for Content	<b>Office of Medical Staff Services</b>

The Office of Medical Staff Services (OMSS) is responsible for the credentialing, recredentialing, and privileging of over 1600 Medical Staff and Allied Health Professionals, who are applying to UNC Hospitals. In addition, the OMSS is responsible for performing this function on behalf of the managed care organizations that have contracts and delegated credentialing agreements with UNC Healthcare.

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## Office of Medical Staff Services Manual

	Policy Name	<b>General Information: Role &amp; Responsibilities: Department Chair</b>
	Policy Number	<b>OMSS 0000</b>
	Date this Version Effective	<b><i>January 2018</i></b>
	Responsible for Content	<b>Office of Medical Staff Services; <i>Bylaws of the Medical Staff</i></b>

### POLICY


Each department or service shall be organized as a division of the staff and shall have a Department Chair or Service Head who is responsible to the Chief of Staff for the ongoing, effective operation of his Department or Service, for improving patient safety, and for continually assessing and improving its activities. Each Department Chair and Service Head is appointed by the Board of Directors upon the recommendation of the Dean of the School of Medicine, except that the Chair of the Department of Dentistry is appointed upon recommendation of the Dean of the School of Dentistry. Each Department Chair must be certified by an appropriate specialty board or comparable competence affirmatively established through the credentialing process.

### RESPONSIBILITIES

The key role and responsibilities of each Department Chair (per the *Bylaws of the Medical Staff*) include, but are not limited to the following:

1. All clinically related activities of the department/service;
2. All administratively related activities of the department/service, unless otherwise provided for by the Hospital or University;
3. Continuing surveillance of the professional performance of all individuals who have delineated clinical or practice privileges in the department/service;
4. Recommending to the Medical Staff the criteria for clinical or practice privileges that are relevant to the care provided in the department/service;
5. Recommending clinical or practice privileges for each member of the department/service;
6. Assessing and recommending off-site resources for needed patient care services not provided by the department/service or the Hospital;
7. The integration of the department/service into the primary functions of the organization;
8. The coordination and integration of interdepartmental and intradepartmental services;
9. The development and implementation of policies and procedures that guide and support the provision of services;
10. Recommendations for a sufficient number of qualified and competent persons to provide care/service;
11. The determination of the qualifications and competence of department/service personnel who are not licensed independent practitioners and who provide patient care services;
12. The continuous assessment and improvement of the quality of care and services provided;
13. The maintenance of quality control programs, as appropriate;
14. The orientation and continuing education of all persons in the department/service; and
15. Recommendations for space and other resources needed by the department/service.

## Office of Medical Staff Services Manual

	Policy Name	<b>General Information: Role &amp; Responsibilities: Chief Medical Officer</b>
	Policy Number	<b>OMSS 0000</b>
	Date this Version Effective	<b>January 2018</b>
	Responsible for Content	<b>Office of Medical Staff Services; Bylaws of the Medical Staff</b>

### POLICY

The Chief Medical Officer is responsible for the clinical operations of the Hospital. The Chief Medical Officer calls and presides over all regular and special meetings of the Medical Staff. An Associate Chief Medical Officer, in the absence of the Chief Medical Officer, assumes all of the authority and duties of the Chief Medical Officer. The Associate Chief Medical Officer also performs such other duties as may be assigned by the Chief Medical Officer.


### RESPONSIBILITIES

The Chief Medical Officer serves as the Chief Administrative Officer of the Medical Staff and his/her responsibilities are as follows:

1. To work with the President relative to all matters of mutual concern between the Medical Staff and the Hospital;
2. To call and preside at all meetings of the Medical Staff and keep complete and accurate minutes of all meetings;
3. To appoint the membership of all standing, special and multidisciplinary Medical Staff Committees, except the Executive Committee, subject to the approval of the Executive Committee. Unless otherwise set forth in the *Bylaws*, the Chief Medical Officer names all committee Chairs;
4. To serve as an ex-officio member of all Medical Staff Committees;
5. To represent the views, policies, needs and grievances of the Medical Staff to the Board of Directors and the President;
6. To serve as the public spokesperson for the Medical Staff;
7. To report at the biannual Medical Staff meeting regarding Medical Staff affairs;
8. To enforce the *Bylaws of the Medical Staff*, the *Rules and Regulations of the Medical Staff* and related Policies and Manuals and implement and monitor sanctions or corrective action taken pursuant to the *Bylaws*; and
9. To serve as the Chair of the Executive Committee.

The Medical Staff delegates to the Medical Executive Committee authority to oversee the operations of the Medical Staff. With the assistance of the Chief Medical Officer, and without limiting this delegation of authority, the Medical Executive Committee is responsible for making recommendations to the Board of Directors for its approval concerning:

1. The structure of the Medical Staff;
2. The mechanisms used to review credentials and to delineate individual clinical or practice privileges;
3. Recommendations of individuals for Medical Staff membership;
4. Recommendations for delineated clinical or practice privileges for eligible individuals;
5. Participation of the Medical Staff in performance improvement activities;
6. The mechanisms for terminating Medical Staff membership; and
7. The mechanisms for Fair Hearing procedures.

	Policy Name	<b>Medical Staff: Initial Appointment, Reappointment &amp; Clinical Privileges</b>
	Policy Number	<b>OMSS 0001</b>
	Date this Version Effective	<b>January 2018</b>
	Responsible for Content	<b>Office of Medical Staff Services; Bylaws of the Medical Staff</b>

**I. DESCRIPTION**

This policy is about the initial appointment, reappointment, and privileging process for physicians and dentists applying to the Medical Staff of UNC Hospitals.

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**II. RATIONALE**

The Office of Medical Staff Services is responsible for administering the appointment, reappointment, and privileging process for all physician and dentist applicants in accordance to the *Bylaws of the Medical Staff* and in compliance with applicable accreditation and regulatory standards.

**III. POLICY**

Membership on the Medical Staff of the University of North Carolina Hospitals is a privilege extended only to physicians and dentists who continuously meet the qualifications, standards and requirements set forth in the *Bylaws of the Medical Staff*. Membership on the Medical Staff confers only those clinical privileges and prerogatives granted to the member by the Board of Directors in accordance with the *Bylaws*. Appointments to the Medical Staff are made without regard to race, religion, color, age, sex, national origin, disability, or sexual orientation, provided the individual is competent to render care consistent with the professional level of quality and competence established by the Medical Staff Executive Committee and the Board of Directors. All appointees are assigned to a specific clinical department.

**A. Categories and Criteria for Initial Appointment**

Initial appointments to the Medical Staff are made by the Board of Directors and are to one of the following categories of the staff (as defined in the *Bylaws of the Medical Staff*):

## 1. Active Staff

- All members of the Active Staff must hold a faculty appointment in the School of Medicine or the School of Dentistry of the University of North Carolina at Chapel Hill.
- The Active Staff consists of physicians and dentists who have successfully completed an Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), or Commission on Dental Accreditation (CODA) residency training program in the specialty in which the applicant seeks clinical privileges.
- Each Department Chair must be certified in his/her specialty by a member board of the American Board of Medical Specialties (ABMS) or the American Dental Association (ADA) or possess comparable competence.
- In addition, after January 1, 2002, each new applicant to the Active Staff must be either certified, or in preparation for certification, by a member board of the ABMS or an ADA recognized specialty or subspecialty in which the applicant seeks clinical privileges.
- Physicians and dentists who apply for Active Staff membership prior to obtaining board certification may be accorded Active Staff status not to exceed a period of two (2) years during which time the physician or dentist must successfully obtain board certification.
- If a specialty board requirement would preclude board certification within the two (2) year period, the physician or dentist must successfully obtain board certification within six (6) years of initial appointment, unless an earlier time period is identified by his board.
- Time to successfully achieve board certification may be extended for an additional period of one (1) year upon determination of good cause. If a member of the Active Staff fails to obtain board certification within these time limits, or is found to be ineligible for further preparation for board certification, the Active Staff appointment will terminate automatically and such physician or dentist will not be entitled to the Hearing and Appellate Review procedures. Following board certification, failure of a subsequent required or optional board certification examination by a member of the Active Staff will not automatically result in termination of Medical Staff membership.
- Physicians or dentists who are certified by boards other than a member board of the ABMS or ADA recognized specialty, and/or who receive their specialty training in countries other than the United States or Canada, must receive the specific recommendation of the Department Chair prior to consideration by the Credentials Committee, and will be evaluated for Active Staff membership according to criteria relative to education, current licensure, training, experience, and current competence.
- Members of the Active Staff are appointed to a specific department. They have primary responsibility for patient care and clinical education, and are entitled to exercise those clinical privileges granted to them by the terms of their appointment or reappointment.
- Within the scope of their clinical privileges, the Department Chair may administratively assign clinical responsibilities to Active Staff to best meet patient care and/or departmental needs at UNC Hospitals and the outpatient clinics, services and programs of the School of Medicine of the University of North Carolina at Chapel Hill and the University of North Carolina Health Care System.
- All members of the Active Staff, **except those who hold an appointment of Fellow or Clinical Instructor** on the faculty of the School of Medicine or the School of Dentistry of the University of North Carolina at Chapel Hill, are entitled to vote, hold office and serve on Medical Staff committees. Those members of the Active Staff who hold such Fellow or Clinical Instructor faculty appointments are entitled to serve on Medical Staff committees, but may not vote or hold office.

## 2. Affiliate Staff

- The Affiliate Staff consists of physicians and dentists who have an office-based practice and refer patients to the inpatient services or procedural areas of UNC Hospitals.
- Appointment to the Affiliate Staff is intended for the purpose of coordination of care and appropriate follow-up of the Affiliate Staff's patients after treatment at UNC Hospitals.
- Members of the Affiliate Staff are not eligible for clinical privileges or admitting privileges, and are not entitled to vote on Medical Staff matters.

- Members of the Affiliate Staff may visit patients they have referred to UNC Hospitals and may have “read only” access to the patients’ paper and electronic medical record but may not write orders or entries of any kind in the medical record.
- Affiliate Staff may attend clinical conferences, seminars, educational programs, Medical Staff and Department meetings and use the Health Sciences Library.

### **3. Telemedicine Staff**

- The Telemedicine Staff consists of physicians or dentists who are contracted by UNC Hospitals to provide services to UNC Hospitals patients via telemedicine link.
- Telemedicine services shall include any of the following when provided via telemedicine link: consulting, prescribing, rendering a diagnosis, or providing an official reading of images, tracings or specimens. A telemedicine link is defined as the use of electronic communication or other communication technology to exercise telemedicine privileges at a distance.
- Members of the Active are not required to be a member of the Telemedicine Staff in order to provide telemedicine services.
- The Telemedicine Staff consists of physicians and dentists who are board certified or who possess all of the qualifications for board certification and are otherwise professionally qualified to attend patients in the Hospital.
- Members of the Telemedicine Staff are not eligible for admitting privileges and are not entitled to vote on Medical Staff matters.
- Telemedicine Staff membership is granted as a courtesy and not as a right and Telemedicine Staff members may be dismissed from the Telemedicine Staff at the discretion of the Medical Staff Executive Committee. Neither the granting, denial, or termination of Telemedicine Staff membership shall entitle the individual concerned to any of the procedural rights provided in Article IX, Article X or any other right set forth in the Bylaws.

### **4. Courtesy Staff**

- A member of the Courtesy Staff must be a member of the Active Medical Staff of another hospital where s/he actively participates in quality improvement activities similar to those required of the Active Staff at UNC Hospitals.
- Appointment to the Courtesy Staff is intended to be a limited appointment for purposes of occasional inpatient admissions or outpatient care in accord with those clinical privileges as granted by the terms of the appointment, the goals of the Hospital, bed availability, and the needs of the Active Staff and their patients.
- The Courtesy Staff consists of physicians and dentists who are board certified or who possess all of the qualifications for board certification and are otherwise professionally qualified to attend patients in the Hospital.
- They are not required to hold a faculty appointment in the School of Medicine or the School of Dentistry of the University of North Carolina at Chapel Hill. (For purposes of these Bylaws, physicians and dentists who are certified or qualified for certification by a member board of the American Board of Medical Specialists (ABMS) or by the American Dental Association (ADA) satisfy the requirement for board certification.
- Physicians and dentists who are certified or qualified for certification by boards other than a member board of the ABMS or the ADA are evaluated as to eligibility for Courtesy Staff based upon criteria relative to education, current licensure, training, experience, and current competence.
- Courtesy Staff are appointed to a specific department and may attend meetings of the Medical Staff and Department to which they are appointed, but are not eligible to vote, hold office, or serve on Medical Staff Committees.

### **5. Visiting Staff**

- The Visiting Staff consists of physicians and dentists who have privileges at another hospital and whose purpose at the Hospital is for limited educational purposes.



- Visiting Staff may not independently treat patients and must work under the direct supervision of an Active Medical Staff member.
- They are not eligible to admit patients, vote, hold office, or serve on Medical Staff Committees and may be dismissed from the Visiting Staff at the discretion of the Medical Staff Executive Committee or Chief Medical Officer.
- Neither the granting, denial nor termination of Visiting Staff membership shall entitle the individual concerned to any of the procedural rights provided in Article IX, Article X or any other right set forth in the Bylaws. Visiting Staff membership requires the express approval of the Chief Medical Officer or his/her designee.

#### **6. Locum Tenens Staff**

- The Locum Tenens Staff consists of physicians and dentists appointed to assist or temporarily fulfill the responsibilities of a member of the Active Staff.
- The Locum Tenens Staff consists of physicians and dentists who are board certified or who possess all the qualifications for board certification and are otherwise professionally qualified to attend patients in the Hospital.
- The Locum Tenens Staff shall have delineated clinical privileges.
- The appointment to the Locum Tenens Staff shall be for no more than one year.
- The Locum Tenens Staff are not eligible to vote, hold office, or serve on Medical Staff Committees and may be dismissed from the Locum Tenens Staff at the discretion of the Medical Staff Executive Committee.
- Neither the granting, denial or termination of Locum Tenens Staff membership shall entitle the individual concerned to any of the procedural rights provided in Article IX, Article X or any other right set forth in the Bylaws.

#### **7. Honorary Staff**

- The Honorary Staff consists of physicians and dentists who are recognized by the Hospital for their professional eminence or their noteworthy contributions to the health and medical sciences.
- They are not eligible to admit patients, vote, hold office, or serve on Medical Staff Committees.

### **B. Delineation of Clinical Privileges**

Medical Staff membership confers upon the appointee only those clinical privileges delineated in the notice of appointment. The exercise of such privileges within any Department is subject to the rules and regulations of that Department and to the authority of the Department Chair. All requests for clinical privileges are processed pursuant to the procedures for appointment in the *Bylaws*.

Every application for staff appointment contains a statement of the specific clinical privileges being requested by the applicant. The applicant has the burden of establishing his/her qualifications for the clinical privileges requested. A request for clinical privileges is evaluated based upon the criteria set forth in the *Bylaws*, and other reasonable evidence of current ability to perform the privileges requested, including, but not limited to:

- peer recommendations;
- ethical character;
- ability to work with others;
- assessment, as appropriate, of an applicant's documented experience in categories of treatment areas or procedures, the results of treatment, and the conclusions drawn from relevant practitioner-specific data compared to aggregate data, performance measurement data, and morbidity and mortality data, when available.

### C. **Application Process**

All initial appointment applications and requests for clinical privileges must be initiated by, requested, and recommended by the Chair of one of the following clinical department in which the applicant is requesting appointment and clinical privileges: Anesthesiology, Dentistry, Dermatology, Emergency Medicine, Family Medicine, Internal Medicine, Neurology, Neurosurgery, Obstetrics/Gynecology, Ophthalmology, Oral & Maxillofacial Surgery, Orthopaedics, Otolaryngology/Head & Neck Surgery, Pathology & Laboratory Medicine, Pediatrics, Physical Medicine & Rehabilitation, Psychiatry, Radiation Oncology, Radiology, Surgery and Urology.

The Department Chair is responsible for reviewing the application and supporting documentation and transmitting to the Office of Medical Staff Services a written recommendation to the Credentials Committee to appoint the applicant to the Medical Staff, reject the applicant for staff membership, or defer the application for further consideration. Where appointment is recommended, the Chair further recommends the clinical privileges to be granted and any special conditions to be attached to the appointment. The Credentials Committee, through the Office of Medical Staff Services, will seek confirmation of the Chair's recommendation upon receipt during the verification process of new or additional information that was not available to the Chair when s/he first reviewed the application.

1. The UNC **Departmental Credentialing Coordinator/designee**, upon notification by their Department Chair (or departmental designee) of a new hire that will require Medical Staff appointment and clinical privileges:
  - initiates the credentialing process by completing a “*Request for Initial Appointment Application Packet*” form; and
  - submitting the form to their Credentialing Specialist in OMSS,
2. The **OMSS** is then responsible for compiling the following materials, which make up an **initial appointment application packet** and sending the packet to the Departmental Credentialing Coordinator:
  - Initial Appointment Application Checklist (*for use by Applicant*)
  - Appointment Application
  - Clinical Privileges Request Form(s)
  - UNC Healthcare System - Confidentiality Statement
  - Coding & Compliance Training Instructions
  - Criminal History Screening Authorization
  - Physician Acknowledgement Statement
  - Sedation/Analgesia Privileges Request Form/Checklists
  - Uniform Application Attestation Statement
  - Medical Staff Documents Certification Form
  - Applying for a NC DEA Information Sheet
  - Claims History Questionnaire
  - Applying for an NPI Information Sheet
  - UNC Liability Insurance Trust Fund – Memorandum of Coverage

The **Departmental Credentialing Coordinator/designee** also receives the following additional forms to complete:

- Initial Appointment Application Checklist (*for use by DCC/designee*);
- Liability Insurance Confirmation Form

3. The **Departmental Credentialing Coordinator/designee** is responsible for:

- distributing the application packet to the applicant;
  - establishing a deadline for the applicant to return the packet to them;
  - monitoring the return of the application packet; and
  - following-up with the applicant if packet is not returned by the specified deadline (*i.e.* 2 weeks).
4. The **Applicant** is responsible for returning the completed application packet, along with the following additional information, to their Departmental Credentialing Coordinator/designee by the deadline specified:
- certificate of professional liability insurance;
  - current curriculum vitae, which must account for all time since medical school and include month/year format for all from/to dates;
  - supporting documentation (i.e. details regarding any claims history, attorney information, explanation of gaps in training/employment, etc.).
  - electronic signature is acceptable as it is password-protected, specific to the applicant.
5. The **Departmental Credentialing Coordinator/designee** is then responsible for:
- reviewing the application packet for completeness prior to submitting to OMSS by using the designee/DCC's "*Initial Appointment Application Checklist – Coordinator*" provided by OMSS, assuring forms are current and signatures are not older than 30 days;
  - following-up with the applicant for any missing or out-dated documentation;
  - preparing a letter from the Department Chair, that requests and recommends appointment of the applicant and specifies the staff category requested, UNC faculty rank, and anticipated start date;
  - obtaining the Department Chair (and Division Chief, if applicable) signature on the applicant's clinical privileges request form(s);
  - checking the clinical privileges request form to see if applicant is requesting any special privileges that require a separate privilege form and documentation (i.e. laser, cyberknife, robotic, sedation). If yes, then making sure the applicant has attached the additional form and documentation to the clinical privileges request form;
  - if application is going to be a non-ACGME Chief Resident or Clinical Fellow, then makes sure the supplemental CR/CF privilege form is also completed;
  - completing the "Liability Insurance Confirmation Form"(UNC only);
  - submitting the application packet to their Credentialing Specialist in the Centralized Credentialing Office (CCO).
  - serving as the liaison between OMSS/CCO and the applicant/department personnel on the status of the application; assisting OMSS/CCO with any difficulties in obtaining required information.

#### **D. Incomplete Applications**

The **Departmental Credentialing Coordinator** (DCC) is responsible for submitting a complete initial appointment application to the Centralized Credentialing Office (CCO) by the specified deadline. The credentialing process cannot be initiated on any incomplete application packet. Incomplete application packets will be put on hold, thus creating a delay in the initiation of the credentialing process.

Upon receipt, the CCO **Credentialing Specialist** will review the application packet for completeness, current documents, signatures/dates, discrepancies, gaps in training/experience, malpractice claims, and that all required forms have been included, as necessary. Checks to make sure applicant has signed the application, attesting to the correctness and completeness of the application, and that the signature is not > 30 days old. The application and signature attestation must be no more than 180 days old at the time it is presented to the Credentials Committee.

Within 15 days after receipt of an incomplete application, the **Credentialing Specialist** shall:

1. Send an e-mail to the applicant explaining/listing what is missing/ incomplete/out-of-date information or supporting documents. The notice to the applicant/Departmental Credentialing Coordinator/Designee shall include:
  - a complete and detailed description of all of the missing or incomplete information or documents that must be submitted in order for review of the application to continue;
  - the name, address, and telephone number of an individual who will serve as a contact person for the applicant.
2. If the missing information, documents, etc. have not been received within 60 days after initial receipt of the application or if date-sensitive information has expired, the Credentialing Specialist shall send a letter to the Designee/DCC/applicant notifying them that the application is being “pended” for a period up to 120 days from the initial date received in CCO. Also, the Designee/DCC/applicant is notified in writing on an ongoing basis of the missing or incomplete information.

**E. Complete Applications**

Within 60 days after receipt of a complete application packet and all supporting documents, the CCO **Credentialing Specialist** shall verify the applicant’s qualifications (to determine if applicant meets the minimum criteria for Medical Staff appointment and/or clinical privileges) and notify the applicant/Departmental Credentialing Coordinator of its decision. If, by the 60<sup>th</sup> day after receipt of the application, CCO has not received all of the information or verifications it requires from third parties, or date-sensitive information has expired, the **Credentialing Specialist** shall issue a written notification to the Departmental Credentialing Coordinator/applicant “pending” the application and detailing attempts to obtain the information or verifications. Applications shall be pended for a period not to exceed 120 days from the date the application was initially received by CCO.

However, applications cannot be “pended” if the only element lacking is review by the Credentials Committee. Therefore, based on authority delegated by the Credentials Committee to the Chair of the Credentials Committee, such applications may be reviewed by the Chair and granted temporary approval if they meet the credentialing requirements\*\*. Any applications reviewed and granted temporary approval in this manner will be presented formally to the Credentials Committee at their next scheduled meeting for reaffirmation.

*\*\*Criteria used to determine if an applicant warrants specific discussion by the Credentials Committee prior to a decision being made on their credentialing include:*

- Excessive number of malpractice lawsuits;
- Single malpractice lawsuit of \$500,000 or greater;
- Practitioner having a DEA that is restricted (not self-restricted);
- Any quality issues (i.e. criminal offense, illness/addiction which would impair his/her ability to practice medicine, licensure restrictions, removal of hospital privileges, etc.);
- Multiple quality of care “complaints/incidents” ; and
- Other issues as determined by OMSS staff or the Chair of the Credentials Committee.

A **complete application packet** should include the following documents:

- Letter from Department Chair Requesting/Recommending Appointment & Clinical Privileges (UNC only)
- Application for Appointment & Clinical Privileges

- Clinical Privileges Request Form(s) and any special privilege forms/documentation (i.e. laser)
- UNC Healthcare System Confidentiality Statement
- Copy of Certificate of Insurance, *if applicant will be covered by outside insurance carrier for professional liability*;
- Criminal Background Check Authorization Letter
- Current Curriculum Vitae
- Liability Insurance Confirmation Form
- Physician Acknowledgment Statement
- supporting documentation (i.e. details regarding any claims history, attorney information, explanation of gaps in training/employment, etc.)
- Uniform Provider Credentialing Application Attestation Statement

## **F. Credentialing Process**

Once the packet containing the application materials is “deemed” complete, the credentialing process can be initiated. The credentialing process typically takes a minimum of 90 days for a clean file, but can take up to 180 days for a problematic file (i.e. foreign graduate, multiple affiliations, claims history, disciplinary actions, etc.). All documents shall be dated and initialed.

The CCO Credentialing Specialist is responsible for the following:

- 1. Creates an individual file for the applicant:**
  - completes file workflow and places application materials in the appropriate file sections;
- 2. Adds applicant data to the Echo credentialing system:**
  - generates a copy of the “Uniform Application to Participate as a Healthcare Practitioner”;
  - reviews the copy to assure that all data fields are populated appropriately;
  - attaches the original, signed Uniform Application Attestation page;
- 3. Verifies a valid and current DEA certificate registration (if applicable) via the online US Department of Justice, Office of Diversion control website for all physicians and dentists:** *\*see UNC Hospitals DEA policy on specific requirements*
  - views verification, dates/initials document;
  - reviews response for any DEA restrictions on schedules;
  - if any restrictions identified, requests written explanation from applicant and investigates, as necessary;
  - compares copy of DEA certificate provided by applicant to assure it is current and matches data response;
  - uploads the current DEA information into Echo system;
  - places it in the applicant’s file, and notes on file workflow.
- 4. Requests evaluations from two or more peer references knowledgeable about the applicant’s professional performance, including an assessment for proficiency in the following areas: patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice:**
  - sends cover letter, evaluation form, and copy of the clinical privileges request form to the names provided by the applicant on their application;

- reviews reference evaluations when received for any performance problems, confirmation of current health status, current competence to perform privileges being requested, discrepancies in training and/or employment dates, etc.
- assures “peer” references are obtained (i.e. M.D./M.D., DDS/DDS);
- notifies Director/Office Manager of any negative evaluations and sends to Department Chair for review, as necessary.

**5. Verifies current, valid license to practice:**

*If applicant has not yet received licensure, Credentialing Specialist monitors status until temporary or permanent license has been received, which is required prior to review by Credentials Committee.*

**M.D./D.O.**

- queries the NC Board of Medical Examiners’ database by secure internet access;
- adds the applicant to the NCBME “favorites” DataLiNC list;
- views license information profile on each applicant and initials/dates;
- reviews profile for license status, restrictions, etc;
- if public file is noted, prints a copy of documents for the file;
- investigates any problems and sends to Department Chair for review;
- uploads the current license information profile into Echo system;
- places all in the applicant’s file and notes on file workflow.

**DDS/DMD**

- queries the NC Board of Dental Examiners license database;
- prints license information profile on each applicant and initials/dates;
- reviews profile for license status, disciplinary actions (i.e. good standing);
- investigates any problems and sends to Department Chair for review;
- uploads the current license information profile into Echo system;
- places all in the applicant’s file and notes on file workflow.

**6. Verifies past/present out-of-state licensure for DDS/DMD’s:**

*AMA reports past/present licensure information on M.D./D.O.’s only.*

- queries the appropriate state licensure board if applicant has indicated past/present out-of-state license;
- checks for sanctions or limitations on licensure;
- investigates any problems and sends to Department Chair for review;
- places it in the applicant’s file and notes on file workflow.

**7. Verifies education, training, and board certification:**

**M.D./D.O.**

- queries the AMA or AOA physician database;
- reviews AMA or AOA profile for verifications and compares with what applicant provided;
- if unable to verify degree, training, board certification, other through the AMA/ AOA profile then writes for primary source verification directly from the institution;
- for all foreign medical graduates, submits “certification verification” via ECFMG’s online services; reviews and compares information received with what applicant provided;
- files information in the applicant’s file and notes receipt on file workflow.

**DDS/DMD**

- queries online the appropriate institution for primary source verification of degree, education, training, board certification;

- if unable to verify online, then writes for primary source verification directly from the institution;
- reviews and compares information received with what applicant provided;
- files information in the applicant's file and notes receipt on file workflow.

**8. Work history/Hospital Affiliation:**

- reviews application and/or curriculum vitae:
  - for education/training/work history, including month/year;
  - notes review on checklist, dates/initials;
  - for any gaps greater than 90 days obtains written clarification from the applicant of any gaps in education/training/work history;
  - notes on file workflow and documentation is placed in file.
- verifies all current and past 5 years hospital affiliations and work history:
  - sends affiliation verification form to facility that the applicant has/had appointment and/or clinical privileges and/or work history
  - reviews response and compares with information provided by applicant;
  - if any problems noted, investigates and sends to Department Chair for review;
  - places in applicant's file, and notes receipt on file workflow.

*All Courtesy Staff applicants must hold an Active Staff appointment at another hospital where he/she actively participates in quality improvement activities similar to those required of the Active Staff at UNC Hospitals.*

**9. Requests a criminal background check from Insight/FirstPoint Resources:**

- completes and submits online query ;
- prints and dates/initials final response;
- reviews response for any misdemeanor, felony, SS#, other problems; notifies Director/Office Manager of any problems and sends to Department Chair for review;
- places it in the applicant's file, and notes on file workflow.

**10. Verifies the NPI number via the NPI Registry on the National Plan and and Provider Enumeration System website:**

- notes on file workflow.

**11. Reviews professional liability insurance information and claims history:**

- **New Appointment Coverage:**  
*coverage must be in effect at the time of review by the Credentials Committee*
  - reviews Liability Insurance Confirmation Form(UNC only);
  - indicates on file workflow whether applicant will be covered by Hospitals self-insured policy or an outside carrier;
  - if applicant will be covered by an outside carrier:
  - obtains current certificate of insurance and claims history.
- **Current/Past Coverage (for a minimum of past 5 years):**
  - Reviews 5 years malpractice coverage provided by the applicant
- **Claims History:**
  - Reviews 5 years claims history provided by the applicant

12. **Queries online the following outside agencies for information on state/federal sanctions/restrictions on licensure, limitations on scope of practice, and Medicare/Medicaid sanctions or opt-outs:**
- the **American Medical Association (AMA)** or the **American Osteopathic Association (AOA)** for physicians only – *see #7 above*
  - the **National Practitioner Data Bank (NPDB)** for all physicians/dentists:
    - a) downloads/views NPDB response;
    - b) reviews response for malpractice, sanctions, or disciplinary actions;
    - c) investigates any problems and sends to Department Chair for review;
    - d) places all in the applicant's file and notes on file workflow.
  - the **Office of Inspector General (OIG)** and System for Award Management (SAM) on all physicians/dentists:
    - a) views response, dates/initials document;
    - b) reviews response for Medicare/Medicaid sanctions;
    - c) investigates any problems and sends to Department Chair for review;
    - d) places all in the applicant's file and notes on file workflow.
  - the **Centers for Medicare & Medicaid Services (CMS)** on all physicians/dentists:
    - a) reviews "Report of Providers Opted Out of Medicare" for applicant's name;
    - b) indicates on checklist;
    - c) if applicant name appears, notifies Director/Office Manager for resolution.
13. **Reviews "onsite assessments" of clinic facilities and medical/treatment record-keeping submitted by any managed care organizations (this is in addition to UNCH accreditation documents from Joint Commission):**
- notes review on file workflow, indicating whether the standards were met;
  - if standards were not met, notes on file checklist and attaches copy of documentation. (*\*see P&P – Managed Care/Delegated Credentialing*)
14. **Reviews all documentation received from outside sources:**
- compares information with what was provided by the applicant;
  - if any discrepancies are found, contacts the applicant promptly and gives them an opportunity to correct any erroneous information (*\*see specific policy on "Practitioner's Rights" for details*).
15. **Monitors expiration dates of all documents:**
- obtains updated documents (i.e. board certification, certificate of insurance, license, DEA registration);
  - scans and maps the updated documents into the Echo system
  - monitors the expiration dates for all elements that require verification within 180 days of review by Credentials Committee;
  - re-queries or re-verifies information, as necessary.
16. **Tracks application status:**
- follows-up on requested information not returned in a timely fashion (i.e. weekly);
  - updates the Departmental Credentialing Coordinator on a weekly basis of the file's status;
  - notifies the Departmental Credentialing Coordinator/designee and/or applicant whenever difficulties arise in obtaining required documentation. Departmental Credentialing Coordinator/designee and applicant are responsible for assisting the OMSS/CCO in



obtaining any missing documentation by contacting the individuals or outside agencies and asking them to submit to the OMSS/CCO as requested.

**G. Expedited Credentialing and Privileging Process**

To expedite initial appointments for Medical Staff membership and granting of clinical privileges, the Board of Directors has delegated the authority to render those decisions to the Healthcare System Credentialing Subcommittee of the Board of Directors. This Credentialing Subcommittee is comprised of the Chair of the Joint Conference and Quality Committee of the Board, the President of UNC Hospitals, and the President of UNC Faculty Physicians.

In accordance with policies adopted by the Board of Directors, the Credentials Committee determines whether the application qualifies for expedited consideration by the Medical Staff Executive Committee or contains issues that require presentation at the Executive Committee. Applications that do not qualify for expedited consideration include, but are not limited to, where the applicant:

- Has a current or a previously successful challenge to licensure or registration;
- Has received an involuntary termination of Medical Staff membership at another organization;
- Has been subject to disciplinary action by a state licensing or certification board, professional society, or other healthcare organization;
- Has received involuntary limitation, reduction, denial, or loss of clinical privileges;
- Has received questionable or negative peer reference evaluations; or
- Has been an unusual pattern of, or excessive number of, professional liability actions against the applicant.

The expedited credentialing and privileging process may be used only when all of the following conditions are met:

- The applicant submits a complete application that has been reviewed and verified by the Office of Medical Staff Services in accordance with the procedures and criteria specified in the *Bylaws of the Medical Staff*;
- The application has been reviewed and recommended for approval by the Credentials Committee of the Medical Staff; and
- The application is reviewed and recommended for approval by the Medical Staff Executive Committee and the recommendation for approval is neither adverse to the applicant nor has any limitations.

**H. Review and Approval Process**

When verification by the Office of Medical Staff Services is complete, the Credentials Committee reviews the application, the supporting documentation, the Department Chair's report and recommendations, and such other information relevant to the staff category, department and service affiliation, and clinical privileges requested by the applicant. The Credentials Committee then recommends that the Executive Committee appoint the applicant to the Medical Staff, reject the applicant for staff membership, or the Credentials Committee defers the application for further consideration. Where appointment is recommended, the Credentials Committee further recommends the staff category, department, and service affiliations, the clinical privileges (core and/or special, or office practice only) to be granted, and any limitations to the privileges or conditions to be attached to the appointment. In addition, the Credentials Committee, in accordance with policies adopted by the Board of Directors, determines whether the application qualifies for expedited consideration by the Executive Committee or contains issues that require presentation at the Executive Committee. Applications that do not qualify for expedited consideration include those with concerning patterns of medical liability or professional

performance at prior institutions or other matters revealed in the applicant's background and reference checks.

1. **OMSS ensures that credentialing information is reviewed for completeness and accuracy before being forwarded to the Credentials Committee:**
  - Credentialing Specialist gives file to the **Manager** to review;
  - Manager reviews file to make sure all required elements are present and current;
  - Manager returns file to Credentialing Specialist if any required elements are missing or out-of-date;
  - Manager determines whether a file meets the credentialing requirements and will require review and administrative approval by the Chair of the Credentials Committee prior to the next scheduled Credentials Committee meeting.
2. The **Chair of the Credentials Committee** reviews any files the Manager/Director has identified as requiring review and administrative approval prior to the next Committee meeting. The Chair has the authority to sign off on files as complete, clean and administratively approved. Any files that are reviewed and granted administrative approval by the Chair will be presented formally to the Credentials Committee at their next meeting for reaffirmation.
3. The **Manager** develops ballot of acceptable/complete applications for the Credentials Committee. Any applications that have already been reviewed by the Chair of the Credentials Committee and granted administrative approval are also included on the ballot.
4. The **Credentials Committee** review of appointment applications occurs monthly, or as needed. The Credentials Committee reviews and makes a recommendation to the Executive Committee of the Medical Staff (per *Bylaws*).
5. Following review by the Credentials Committee, **the Manager**
  - files original ballot (signed by Chair of the Credentials Committee), outlier summary, and any meeting handouts;
  - prepares minutes from the meeting and emails to Executive Assistant to hold for distribution with next meeting agenda.
6. The **Manager** then returns the files to the **Credentialing Specialists**, who are responsible for:
  - updating applicant information in ECHO credentialing system;
  - sends email notification of all new applicants via SER distribution list, which includes numerous departments (i.e. Labs, Radiology, UNCP&A, Medical Records, Operating Rooms, Information Services Security, Compliance Office\*);
  - distributing any updated applicant data via SER distribution list;
  - preparing the temporary appointment letters for President's signature within ten business days to the applicants informing them of the Credentials Committee decision when temporary privileges are granted. (*Note: NCQA considers the decision made by the Credentials Committee to be final. However, Joint Commission requires additional review/recommendation by the Executive Committee of the Medical Staff, who then makes recommendation to the Board of Directors for final approval.*)
  - updating applicant information in ECHO credentialing system; and
  - filing approval letter in applicant's packet
7. The **OMSS Credentialing Specialist** is responsible for:
  - making copies of letters, mailing originals and copies to distribution list, and filing; and
  - scanning/sending a copy of signed ballot and blank ballot to UNCP&A Managed Care Office.

8. Based on the Credentials Committee recommendations for each applicant, the **Manager:**
  - develops the ballot of complete applications for review by the Medical Staff Executive Committee (MSEC), indicating which applicants met the criteria for expedited credentialing and those applicants that did not meet the criteria;
  - prepares and emails ballot to the Chief of Medical Officer's Executive Assistant for inclusion in the agenda packet for the next Executive Committee meeting;
  - files copy of ballot in the MSEC email folder.
9. The **Executive Committee** reviews the Credentials Committee's recommendations monthly and makes a recommendation to the UNC Health Care System's Board of Directors (per *Bylaws*).
10. Following review by the Medical Staff Executive Committee, the Chief of Medical Officer's Executive Assistant notifies OMSS of their decision, at which point the **Director:**
  - develops the ballot(s) of complete applications for review by the Credentialing Subcommittee of the Board of Directors (for those applicants that met the criteria for expedited credentialing) and for review by the full Board of Directors (for those applicants that did not meet the criteria for expedited credentialing); gives to the Executive Assistant;
  - emails ballot of applicants that met the criteria for expedited credentialing to the Credentialing Subcommittee of the Board;
  - prepares and emails ballot of applicants that did not meet the criteria for expedited credentialing to the full Board of Directors, as necessary;
  - monitors Board responses by email or fax; follows-up with members if responses not returned by specified deadline.
11. The **Board of Directors** reviews the Executive Committee's recommendations and makes final approval decision (per *Bylaws*).
12. After approval by the Board of Directors, the OMSS **Credentialing Specialists:**
  - updates applicant information in ECHO credentialing system;
  - prepares appointment letters to notify applicants of the final decision by the Board of Directors. These notification letters are signed by the President of UNC Hospitals and mailed to the applicants within 10 business days of the Board meeting (*within 60 days of the Credentials Committee meeting*);
  - includes copy of letter in credentials file; and
  - scans and electronically stores file in Echo system.

#### IV. **POLICY ON REAPPOINTMENT & RENEWAL OF CLINICAL PRIVILEGES**

Continued membership on the Medical Staff of the University of North Carolina Hospitals is a privilege extended only to physicians and dentists who have continuously met the qualifications, standards and requirements set forth in the *Bylaws of the Medical Staff*. All reappointments to the Medical Staff are made by the Board of Directors and are to one of the staff categories, as defined in the *Bylaws of the Medical Staff*, and in this policy (section III, A.).

##### **A. Criteria for Reappointment and Renewal of Clinical Privileges**

Each Department Chair's recommendation concerning the reappointment of a Medical Staff member and the nature and scope of the clinical privileges to be granted upon reappointment is based upon such member's professional performance, including relevant practitioner-

specific data compared to aggregate data, performance measurement data and morbidity and mortality data, when available; ethics and conduct; attendance and participation in staff affairs; relevant training and/or experience; compliance with the *Bylaws of the Medical Staff* and *Rules and Regulations of the Medical Staff*; cooperation with Hospital personnel; use of the Hospital's facilities for patients; relations with other practitioners and ability to work with others; satisfactory completion of such continuing education requirements as may be imposed by the North Carolina licensing boards, the Hospital, or applicable accreditation agencies; physical and mental capabilities; continuing status on the faculty of the School of Medicine or the School of Dentistry of the University of North Carolina at Chapel Hill, if applicable; contributions towards the Hospital's objectives of patient care, education and research if applicable; and general attitude towards patients, the Hospital and the public.

The Department Chair (or the Chief Medical Officer when a Department Chair applies for reappointment) forwards his/her written recommendations regarding reappointment to the Credentials Committee via the Chair's Evaluation Form (a key part of the practitioner's ongoing professional practice evaluation), which references each of the above elements of performance to at least one of the six general competencies (Patient Care/Clinical Skills, Medical Knowledge, Interpersonal and Communication Skills, Professionalism, Practice-Based Learning and Improvement, and Systems-Based Practice). Thereafter, the procedures set forth in the *Bylaws of the Medical Staff* are followed relative to applications for reappointment and/or renewal of, or changes in clinical privileges granted in connection therewith.

The Chair's Evaluation Form requires the Chair to evaluate each of multiple elements of the practitioner's performance as being satisfactory or unsatisfactory, provide an evaluation of overall performance as satisfactory or unsatisfactory, and then recommend in favor of or against reappointment and renewal of requested privileges. Any overall unsatisfactory evaluations and any recommendation for less than the full requested term of reappointment with all requested privileges disqualifies the applicant from expedited consideration and requires presentation of identified issues to the Executive Committee.

When the overall evaluation is satisfactory, individual unsatisfactory evaluations of specific elements do not necessarily require presentation to the Executive Committee. The Credentials Committee, working with the Office of the Chief Medical Officer and the applicant's Department Chair, may establish a plan for counseling of the individual and ongoing professional practice evaluation over the term of reappointment. When approved by the Board as conditions or terms for reappointment that do not limit the requested scope of clinical privileges or category of appointment, such counseling or practice evaluation or other requirements do not constitute corrective action as defined in the *Bylaws of the Medical Staff*.

#### **B. Application Process**

The Office of Medical Staff Services and the Centralized Credentialing Office are responsible for initiation of the reappointment process by distributing the application packets to the Departmental Credentialing Coordinators (DCC)/designee. The packets are distributed six months (180 days) prior to the applicants' appointment expiration date. This is to allow for ample time for the application to be completed, returned, processed, and reviewed/approved by the Credentials Committee, Medical Staff Executive Committee, and Board of Directors prior to expiration of appointment/privileges. The Joint Commission requires applications for reappointment and renewal of privileges be reviewed/approved prior to their expiration date.

At least ninety (90) days prior to the expiration of each staff member's appointment or reappointment, the Office of Medical Staff Services requests the Department Chair in which the member has clinical privileges to review all pertinent information relative to each staff member eligible for reappointment. All applications for reappointment and renewal of clinical privileges will be processed in accordance with the procedures specified in the *Bylaws of the Medical Staff*.

1. Based on the list of names by department, the **Credentialing Specialists** prepare a reappointment application packet for each individual and sends them to the appropriate Departmental Credentialing Coordinator/designee for distribution to the applicants. The following materials make up a reappointment application packet for the Applicant:

- Reappointment Application Checklist (*for use by Applicant*)
- Reappointment Application
- Clinical Privileges Request Form(s)
- CME Documentation Form
- Online Training Certification Form
- UNC Healthcare System –Confidentiality Statement
- Uniform Provider Credentialing Application Attestation Statement for Managed Care

The Departmental Credentialing Coordinator/designee also receives the following additional forms to complete:

- Reappointment Application Checklist – (*for Departmental Credentialing Coordinator*);
- Liability Insurance Confirmation Form

2. The **Departmental Credentialing Coordinator/designee** is responsible for:

- distributing the application packet to the applicant;
- establishing a deadline for the applicant to return the packet to them;
- monitoring the return of the application packet;
- following-up with the applicant if packet is not returned by the specified deadline.

3. The **Applicant** is responsible for returning the application packet to their Departmental Credentialing Coordinator/designee, along with the following additional information by the deadline specified:

- certificate of professional liability insurance (if they are covered by a new outside carrier);
- supporting documentation (i.e. details regarding any claims history, attorney information, explanations, etc.)
- electronic signature is acceptable as it is password-protected, specific to the applicant.

4. The **Departmental Credentialing Coordinator/designee** is then responsible for:

- reviewing the application packet for completeness according to the *Reappointment Application Checklist* – for Departmental Credentialing Coordinator;
- following-up with the applicant for any missing documentation;
- obtaining the Department Chair (& Division Chief, if applicable) signature on the applicant's clinical privileges request form(s);
- completing/signing the Liability Insurance Confirmation Form;
- assuring all required supporting documentation is provided;
- obtaining Department Chair (& Division Chief, if applicable) signature on the Chair Recommendation Evaluation; and
- submitting the application packet to CCO by the deadline specified.

### **C. Incomplete Applications**

The OMSS/CCO cannot initiate the recredentialing process on an incomplete application. Applications not submitted by specified deadline may not allow enough time to process prior to

expiration of appointment/privileges, thus causing a member's appointment/privileges to be terminated.

**Within 15 days after receipt of an incomplete application**, the Credentialing Specialist shall:

Send a notice to the applicant/Departmental Credentialing Coordinator/designee which include a detailed description of all of the missing or incomplete information or documents that must be submitted in order for review of the application to continue, and the name, address, and telephone number of an individual who will serve as a contact person for the applicant.

or

Return the incomplete application packet and checklist to the Departmental Credentialing Coordinator/designee, who is responsible for either obtaining what is missing (if it is something the department must provide) or contacting the applicant (if it is something the applicant must provide).

#### **D. Complete Applications**

A **complete packet** should include the following documents from the applicant and/or department:

- Application for Reappointment & Renewal of Clinical Privileges
- Clinical Privileges Request Form(s) and any special privilege forms/documentation (i.e. laser)
- UNC Healthcare System Confidentiality Statement
- CME Attestation
- Copy of new Certificate of Insurance, *if applicant is covered by outside insurance carrier for professional liability*;
- supporting documentation (i.e. details regarding any claims history from carrier, etc.)
- Uniform Provider Credentialing Application Attestation Statement
- Facility specific forms

#### **E. Recredentialing Process**

The Office of Medical Staff Services/Centralized Credentialing Office is responsible for the recredentialing process, which involves a series of activities designed to collect, update, verify, and evaluate data relevant to a practitioner's ongoing professional performance. These activities serve as the foundation for objective, evidence-based decisions regarding reappointment to the Medical Staff, and is factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of renewal.

**Once the packet containing the application materials is "deemed" complete, the recredentialing process can be initiated.**

##### **1. Retrieves the individual's credentials file:**

- completes file workflow and maintains application;

##### **2. Updates applicant data in the Echo credentialing system:**

- generates a copy of the "Uniform Application to Participate as a Healthcare Practitioner";
- reviews the application to assure that all data fields are populated appropriately;
- attaches the original, signed Uniform Application Attestation page;
- indicates on workflow that application was populated/checked.

3. **Reviews Department Chair evaluation form(UNC only):**

- reviews evaluations when received for any performance problems, requests for change in privileges and/or staff category;
- any negative evaluations are shared with the Director and Chair of the Credentials Committee for further investigation;
- flags evaluations for review at Credentials Committee.

**Reviews Continuing Medical Education (CME) documentation form:**

- Makes sure CME meets current requirements;
- Has been for meetings the applicant has attended for their own benefit and pertains to their particular specialty/subspecialty;
- Has been for the period since their last appointment.

4. **Reviews the Online Training Certification form:**

- Makes sure applicant has signed and dated the form;
- If not, then contacts the applicant/DCC/designee

5. **Verifies current, valid license to practice:**

**M.D./D.O.**

- queries the NC Board of Medical Examiners database by secure internet access;
- views license information profile on each applicant and initials/dates;
- reviews profile for license status, restrictions, etc;
- if public file is noted, prints a copy of documents for the file;
- investigates any problems and sends to Department Chair for review;
- scans and maps license information profile in the Echo system
- places all in the applicant's file and notes on file workflow.

**DDS/DMD**

- queries the NC Board of Dental Examiners license database;
- views license information profile on each applicant and initials/dates;
- reviews profile for license status, disciplinary actions (i.e. good standing);
- investigates any problems and sends to Department Chair for review;
- scans and maps license information profile in the Echo system
- places all in the applicant's file and notes on file workflow.

6. **Verifies a valid and current DEA certificate registration, if applicable, via the US Department of Justice, Office of Diversion Control for all physicians/dentists:**

*\*see UNC Hospitals DEA policy on specific requirements*

- views verification, dates/initials document;
- reviews response for any DEA restrictions on schedules;
- if any restrictions identified, requests written explanation from applicant and investigates, as necessary;
- scans and maps printed verification in the Echo system
- places it in the applicant's file, and notes on file workflow.

7. **Verifies any additional education, training, and board certification received since last appointment:**

**M.D./D.O.**

- queries the AMA or AOA physician database;
- reviews AMA or AOA profile for verifications and compares with what applicant provided;
- if unable to verify degree, training, board certification, other through the AMA/ AOA profile then writes for primary source verification directly from the institution;
- files information in the applicant's file and notes receipt on file workflow.

**DDS/DMD**

- queries online the appropriate institution for primary source verification of degree, education, training, board certification;
- if unable to verify online, then writes for primary source verification directly from the institution;
- reviews and compares information received with what applicant provided;
- files information in the applicant's file and notes receipt on file workflow.

8. **Reviews Work history:**

*All Courtesy Staff must hold an Active Staff appointment at another hospital where he/she actively participates in performance improvement activities similar to those required of the Active Staff at UNC Hospitals*

- reviews application to make sure it has been updated since last appointment.

9. **Reviews “onsite assessments” of clinic facilities and medical/treatment record-keeping submitted by any managed care organizations (this is in addition to UNCH accreditation documents from Joint Commission):**

- notes review on file checklist, indicating whether the standards were met;
- if standards were not met, notes on workflow t and attaches copy of documentation.  
(\*see P&P – Managed Care/Delegated Credentialing)

10. **Reviews professional liability insurance information and claims history since last appointment:**

**Current Coverage:**

- reviews Liability Insurance Confirmation Form or Certificate of Insurance from outside carriers;
- indicates on file checklist whether applicant continues to be covered by Hospitals self-insured policy or an outside carrier;

**Claims History:**

- reviews information from carrier on any identified claims;

11. **Queries online the following outside agencies for information on state sanctions/restrictions on licensure, limitations on scope of practice, and Medicare/Medicaid sanctions or opt-outs:**



- the **National Practitioner Data Bank (NPDB)** for all credentialed providers:
  - views NPDB response;
  - reviews response for malpractice, sanctions, or disciplinary actions;
  - investigates any problems and sends to Department Chair for review;
  - places all in the applicant's file and notes on file workflow.
- the **Office of Inspector General (OIG)** and System of Award Management (SAM) on all credentialed providers :
  - views response, dates/initials document;
  - reviews response for Medicare/Medicaid sanctions;
  - investigates any problems and sends to Department Chair for review;
  - places all in the applicant's file and notes on file workflow.
- the **Centers for Medicare & Medicaid Services (CMS)** on all credentialed providers:
  - reviews "Report of Providers Opted Out of Medicare" for applicant's name;
  - indicates on file workflow;;
  - if applicant name appears, notifies Director for resolution.

**12. Reviews all documentation received from outside sources:**

- compares information with what was provided by the applicant;
- if any discrepancies are found, contacts the applicant promptly and gives them an opportunity to correct any erroneous information (*\*see specific policy on "Practitioner's Rights" for details*).

**13. Monitors expiration dates of all documents:**

- obtains updated documents (i.e. board certification, certificate of insurance, license, DEA registration);
- monitors the expiration dates for all elements that require verification within 180 days of review by Credentials Committee;
- re-queries or re-verifies information, as necessary.

**14. Tracks application status:**

- follows-up on requested information not returned in a timely fashion (i.e. weekly);
- updates the Departmental Credentialing Coordinator on a weekly basis of the file's status;
- notifies the Departmental Credentialing Coordinator and/or applicant whenever difficulties arise in obtaining required documentation. Departmental Credentialing Coordinator and applicant are responsible for assisting the OMSS/CCO in obtaining any missing documentation by contacting the individuals or outside agencies and asking them to submit to the OMSS/CCO.

**15. Reviews Privileges being requested compared to those previously granted and checks against completed training or requirements necessary for approval.**

**F. Expedited Recredentialing and Privileging Process**

To expedite reappointments for Medical Staff membership and renewal of clinical privileges, the Board of Directors has delegated the authority to render those decisions to the Healthcare System Credentialing Subcommittee of the Board of Directors. This Credentialing Subcommittee is comprised of the Chair of the Joint Conference and Quality Committee of the Board, the President of UNC Hospitals, and the President of UNC Faculty Physicians.

In accordance with policies adopted by the Board of Directors, the Credentials Committee determines whether the application qualifies for expedited consideration by the Medical Staff

Executive Committee or contains issues that require presentation at the Executive Committee. Applications that do not qualify for expedited consideration include, but are not limited to, where the applicant:

- Has a current or a previously successful challenge to licensure or registration;
- Has received an involuntary termination of Medical Staff membership at another organization;
- Has been subject to disciplinary action by a state licensing or certification board, professional society, or other healthcare organization;
- Has received involuntary limitation, reduction, denial, or loss of clinical privileges;
- Has received questionable or negative peer reference evaluations; or
- Has been an unusual pattern of, or excessive number of, professional liability actions against the applicant.

The expedited recredentialing and privileging process may be used only when all of the following conditions are met:


- The applicant submits a complete application that has been reviewed and verified by the Office of Medical Staff Services in accordance with the procedures and criteria specified in the *Bylaws of the Medical Staff*;
- The application has been reviewed and recommended for approval by the Credentials Committee of the Medical Staff; and
- The application is reviewed and recommended for approval by the Medical Staff Executive Committee and the recommendation for approval is neither adverse to the applicant nor has any limitations.

#### **G. Review and Approval Process**

OMSS ensures that recredentialing information is reviewed for completeness and accuracy before being forwarded to the Credentials Committee:

- Credentialing Specialist gives file to the Manager to review;
  - Manager reviews file to make sure all required elements are present and current;
  - Manager returns file to Credentialing Specialist if any required elements are missing or out-of-date;
  - Manager determines whether a file meets the credentialing requirements and will require review and administrative approval by the Chair of the Credentials Committee prior to the next scheduled Credentials Committee meeting.
1. The **Chair of the Credentials Committee** reviews any files the Manager has identified as requiring review and approval prior to the next Committee meeting. The Chair has the authority to sign off on files as complete, clean and approved. Any files that are reviewed and granted approval by the Chair will be presented formally to the Credentials Committee at their next meeting for reaffirmation.
  2. The **Manager** develops ballot of acceptable/complete applications for the Credentials Committee review. Any applications that have already been reviewed by the Chair of the Credentials Committee and granted administrative approval are also included on the ballot.
  3. The **Credentials Committee** review of reappointment applications occurs monthly, or as needed. The Credentials Committee reviews and makes a recommendation to the Executive Committee of the Medical Staff (per *Bylaws*).
  4. Based on the Credentials Committee recommendations for each applicant, the **Manager:**

- develops the ballot of complete applications for review by the Medical Staff Executive Committee (MSEC), indicating which applicants met the criteria for expedited recredentialing and those applicants that did not meet the criteria;
  - emails ballot to the Chief Medical Officer's Executive Assistant for inclusion in the agenda packet for the next Executive Committee meeting;
  - files copy of ballot in the MSEC email folder.
5. The **Executive Committee** reviews the Credentials Committee's recommendations monthly and makes a recommendation to the UNC Health Care System's Board of Directors (per *Bylaws*).
- a. Following review by the Medical Staff Executive Committee, the Chief of Medical Officer's Executive Assistant notifies OMSS of their decision, at which point the **Director/designee**:
- develops the ballot(s) of complete applications for review by the Credentialing Subcommittee of the Board of Directors (for those applicants that met the criteria for expedited recredentialing) and for review by the full Board of Directors (for those applicants that did not meet the criteria for expedited recredentialing);
  - emails ballot of applicants that met the criteria for expedited recredentialing to the Credentialing Subcommittee of the Board;
  - emails ballot of applicants that did not meet the criteria for expedited recredentialing to the full Board of Directors, as necessary;
- b. The **Board of Directors** reviews the Executive Committee's recommendations and makes final approval decision (per *Bylaws*).
6. After approval by the Board of Directors, the OMSS **Credentialing Specialists**:
- Update Echo with applicant information;
  - prepare reappointment letters to notify applicants of the final decision by the Board of Directors. These notification letters are signed by the President of UNC Hospitals and mailed to the applicants within 10 business days of the Board meeting (*within 60 days of the Credentials Committee meeting*);
  - file copy of letter in applicant's credentials file; and
  - scan and store completed packet in Echo system.

	Policy Name	<b>Independent Allied Health Professional: Initial Appointment, Reappointment and Clinical Privileges</b>
	Policy Number	<b>OMSS 0002</b>
	Date this Version Effective	<b>January 2018</b>
	Responsible for Content	<b>Office of Medical Staff Services; Bylaws of the Medical Staff</b>

**I. DESCRIPTION**

This policy is about the initial appointment, reappointment, and privileging process for those providers applying to the Independent Allied Health Professional Staff of UNC Hospitals.

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**II. RATIONALE**

The Office of Medical Staff Services is responsible for administering the appointment, reappointment, and privileging process to all applicants in accordance to the *Bylaws of the Medical Staff* and in compliance with applicable accreditation and regulatory standards.

**III. POLICY ON INITIAL APPOINTMENT AND REQUEST FOR PRIVILEGES**

An Independent Allied Health Professional who applies for privileges must be a member of the faculty or an employee of the School of Medicine, an employee of the Hospital, or a party to a contract with the Hospital. Allied Health Professionals are not a member of the Medical Staff and accordingly shall have no recourse to the procedural rights specified in the *Bylaws of the Medical Staff*. However, they must fulfill all other applicable requirements specified in the *Bylaws of the Medical Staff* and all Medical Staff and Hospital rules, regulations, policies, and procedures.

**A. Criteria for Initial Appointment**

Independent Allied Health Professionals include: acupuncturists; certified clinical geneticists; clinical pharmacists; optometrists; podiatrists; psychologists; holders of doctoral degrees affiliated with the Department of Pathology and Laboratory Medicine, or other departments; and others as designated by the Board. An Independent Allied Health Professional must meet those specific qualifications and may request only those specific practice privileges appropriate to his/her category, as specified by the applicable policies and procedures of the Credentials Committee and the *Bylaws of the Medical Staff*.

**B. Scope of Privileges**

An Independent Allied Health Professional **may not admit patients to or discharge patients** from the Hospital. An Independent Allied Health Professional may, within the scope of his/her professional licensure or certification, his/her practice privileges, and the rules, regulations, policies and procedures of the Medical Staff and the Hospital:

1. provide specified patient care services;
2. exercise independent judgment in his/her areas of competence and participate directly in the management of patients, provided that a member of the Active Staff within the appropriate department or specialty has overall responsibility for the care provided to each patient;
3. enter reports and progress notes into the medical record and write certain treatment orders for specific patients;
4. serve with voting rights on committees of the Medical Staff and attend Medical Staff or department meetings, if invited; and
5. exercise other prerogatives, as specified by the Board.

In the event that an Allied Health Professional's certification or licensure is adversely affected in any manner, his/her practice privileges shall be immediately and automatically restricted, suspended, or terminated accordingly. In the event that an Allied Health Professional's professional liability insurance is terminated for any reason, his/her practice privileges shall be immediately and automatically terminated.

The President or Chief Medical Officer may restrict, suspend, or terminate any or all of the practice privileges of an Allied Health Professional without recourse to the procedural rights specified in the *Bylaws of the Medical Staff*. An Independent Allied Health Professional whose practice privileges are restricted, suspended, or terminated will be notified of the action and the reasons for such action, and may request that such action be reviewed by the Medical Staff Executive Committee. At any such review meeting, the individual may be present and may participate in the review. The individual will be entitled to a written report at the conclusion of the review, but will not be entitled to any further internal review or appeal.

### **C. Application Process**

An application for appointment and privileges will be processed in accordance with the procedures specified in the *Bylaws of the Medical Staff* for initial application to the Medical Staff. After an initial appointment of one year, an Independent Allied Health Professional must apply for reappointment and renewal of practice privileges every two years.

## **IV. POLICY ON REAPPOINTMENT AND RENEWAL OF PRIVILEGES**

Continued membership as an Independent Allied Health Professional at the University of North Carolina Hospitals is a privilege extended only to those who have continuously met the qualifications, standards and requirements set forth in the *Bylaws of the Medical Staff*.

### **A. Criteria for Reappointment and Renewal of Privileges**

Each Department Chair's recommendation concerning the reappointment of an Independent Allied Health Professional and the nature and scope of the practice privileges to be granted upon reappointment is based upon such member's compliance with the requirements outlined in the *Bylaws of the Medical Staff* and *Rules and Regulations of the Medical Staff*; cooperation with Hospital personnel; use of the Hospital's facilities for patients; relations with other Practitioners and ability to work with others; satisfactory completion of such continuing education requirements as may be imposed by the North Carolina licensing boards, the Hospital, or

applicable accreditation agencies; physical and mental capabilities; continuing status on the faculty of the School of Medicine or the School of Dentistry of the University of North Carolina at Chapel Hill, if applicable; contributions towards the Hospital's objectives of patient care, education and research if applicable; and general attitude towards patients, the Hospital and the public.


The Department Chair forwards his/her written recommendations regarding reappointment to the Credentials Committee via the Chair's Evaluation Form (a key part of the practitioner's ongoing professional practice evaluation), which references each of the above elements of performance to at least one of the six general competencies (Patient Care/Clinical Skills, Medical Knowledge, Interpersonal and Communication Skills, Professionalism, Practice-Based Learning and Improvement, and Systems-Based Practice). Thereafter, the procedures set forth in the *Bylaws of the Medical Staff* are followed relative to applications for reappointment and/or renewal of, or changes in practice privileges granted in connection therewith.

The Chair's Evaluation Form requires the Chair to evaluate each of multiple elements of the practitioner's performance as being satisfactory or unsatisfactory, provide an evaluation of overall performance as satisfactory or unsatisfactory, and then recommend in favor of or against reappointment and renewal of requested privileges. Any overall unsatisfactory evaluations and any recommendation for less than the full requested term of reappointment with all requested privileges disqualifies the applicant from expedited consideration and requires presentation of identified issues to the Executive Committee.

When the overall evaluation is satisfactory, individual unsatisfactory evaluations of specific elements do not necessarily require presentation to the Executive Committee. The Credentials Committee, working with the Office of the Chief Medical Officer and the applicant's Department Chair, may establish a plan for counseling of the individual and ongoing professional practice evaluation over the term of reappointment. When approved by the Board as conditions or terms for reappointment that do not limit the requested scope of practice privileges or category of appointment, such counseling or practice evaluation or other requirements do not constitute corrective action as defined in the *Bylaws of the Medical Staff*.

## **V. POLICY ON REAPPOINTMENT AND RENEWAL OF PRIVILEGES**

The procedures for processing initial applications and reappointment applications shall be the same as those described in OMSS 0001 policy.

	Policy Name	<b>Dependent Allied Health Professional: Initial Appointment, Reappointment and Clinical Privileges</b>
	Policy Number	<b>OMSS 0003</b>
	Date this Version Effective	<b>January 2018</b>
	Responsible for Content	<b>Office of Medical Staff Services; Bylaws of the Medical Staff</b>

**I. DESCRIPTION**

This policy is about the initial appointment, reappointment, and privileging process for those providers applying to the Dependent Allied Health Professional Staff of UNC Hospitals.

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**II. RATIONALE**

The Office of Medical Staff Services is responsible for administering the appointment, reappointment, and privileging process to all applicants in accordance to the *Bylaws of the Medical Staff* and in compliance with applicable accreditation and regulatory standards.

**III. POLICY ON INITIAL APPOINTMENT AND REQUEST FOR PRIVILEGES**

A Dependent Allied Health Professional who applies for practice privileges must be a member of the faculty or an employee of the UNC School of Medicine, an employee of the Hospital, or a party to a contract with the Hospital. A Dependent Allied Health Professional is not a member of the Medical Staff, thus shall have no recourse to the procedural rights specified in the Bylaws of the Medical Staff. However, the Dependent Allied Health Professional must fulfill all other applicable requirements specified in the Bylaws of the Medical Staff and all Medical Staff and Hospital rules, regulations, policies, and procedures.

**A. Criteria for Initial Appointment**

The term "Dependent Allied Health Professional" includes: certified registered nurse anesthetists; certified nurse midwives; clinical pharmacist practitioners; nurse practitioners; physician assistants; and others as designated by the Board. A Dependent Allied Health Professional must meet those specific qualifications and may request only those specific practice privileges within the scope of the licensing or certification requirements applicable to his/her profession, and as further specified by the policies and procedures of the Credentials Committee and the Bylaws.

**B. Scope of Privileges**

A Dependent Allied Health Professional must have a collaborative practice agreement or supervising physician agreement with one or more of the Active Staff who will supervise and assume responsibility for his/her patient care activities. An application for practice privileges will

be processed in accordance with the procedures specified in the Bylaws of the Medical Staff. After an initial appointment for one year, a Dependent Allied Health Professional must apply for renewal of practice privileges every two years.

A Dependent Allied Health Professional may not independently admit patients to or discharge patients from the Hospital. A Dependent Allied Health Professional may, within the scope of his/her professional licensure or certification, his/her practice privileges, and the rules, regulations, policies and procedures of the Medical Staff and the Hospital:

1. provide specified patient care services in collaboration with or under the supervision of his/her sponsoring Active Staff member or members;
2. enter reports and progress notes into the medical record and write certain treatment orders for specific patients;
3. serve with voting rights on committees of the Medical Staff and attend Medical Staff or department meetings, if invited; and
4. exercise other prerogatives, as specified by the Board.

In the event that an Allied Health Professional's certification or licensure is adversely affected in any manner, his/her practice privileges shall be immediately and automatically restricted, suspended, or terminated accordingly. In the event that an Allied Health Professional's professional liability insurance is terminated for any reason, his/her practice privileges shall be immediately and automatically terminated.

The President or Chief Medical Officer may restrict, suspend, or terminate any or all of the practice privileges of an Allied Health Professional without recourse to the procedural rights specified in the *Bylaws of the Medical Staff*. A Dependent Allied Health Professional whose practice privileges are restricted, suspended, or terminated will be notified of the action and the reasons for such action, and may request that such action be reviewed by the Medical Staff Executive Committee. At any such review meeting, the individual may be present and may participate in the review. The individual will be entitled to a written report at the conclusion of the review, but will not be entitled to any further internal review or appeal.

### **C. Application Process**

An application for appointment and privileges will be processed in accordance with the procedures specified in the *Bylaws of the Medical Staff* for initial application to the Medical Staff. After an initial appointment of one year, a Dependent Allied Health Professional must apply for reappointment and renewal of practice privileges every two years.

## **IV. POLICY ON REAPPOINTMENT AND RENEWAL OF PRIVILEGES**

Continued membership as a Dependent Allied Health Professional at the University of North Carolina Hospitals is a privilege extended only to those who have continuously met the qualifications, standards and requirements set forth in the *Bylaws of the Medical Staff*.

### **A. Criteria for Reappointment and Renewal of Privileges**

Each Department Chair's recommendation concerning the reappointment of an Dependent Allied Health Professional and the nature and scope of the practice privileges to be granted upon reappointment is based upon such member's compliance with the requirements outlined in the *Bylaws of the Medical Staff* and *Rules and Regulations of the Medical Staff*; cooperation with Hospital personnel; use of the Hospital's facilities for patients; relations with other Practitioners and ability to work with others; satisfactory completion of such continuing education requirements as may be imposed by the North Carolina licensing boards, the Hospital, or applicable accreditation agencies; physical and mental capabilities; continuing status on the



faculty of the School of Medicine or the School of Dentistry of the University of North Carolina at Chapel Hill, if applicable; contributions towards the Hospital's objectives of patient care, education and research if applicable; and general attitude towards patients, the Hospital and the public.


The Department Chair forwards his/her written recommendations regarding reappointment to the Credentials Committee via the Chair's Evaluation Form (a key part of the practitioner's ongoing professional practice evaluation), which references each of the above elements of performance to at least one of the six general competencies (Patient Care/Clinical Skills, Medical Knowledge, Interpersonal and Communication Skills, Professionalism, Practice-Based Learning and Improvement, and Systems-Based Practice). Thereafter, the procedures set forth in the *Bylaws of the Medical Staff* are followed relative to applications for reappointment and/or renewal of, or changes in practice privileges granted in connection therewith.

The Chair's Evaluation Form requires the Chair to evaluate each of multiple elements of the practitioner's performance as being satisfactory or unsatisfactory, provide an evaluation of overall performance as satisfactory or unsatisfactory, and then recommend in favor of or against reappointment and renewal of requested privileges. Any overall unsatisfactory evaluations and any recommendation for less than the full requested term of reappointment with all requested privileges disqualifies the applicant from expedited consideration and requires presentation of identified issues to the Executive Committee.

When the overall evaluation is satisfactory, individual unsatisfactory evaluations of specific elements do not necessarily require presentation to the Executive Committee. The Credentials Committee, working with the Office of the Chief Medical Officer and the applicant's Department Chair, may establish a plan for counseling of the individual and ongoing professional practice evaluation over the term of reappointment. When approved by the Board as conditions or terms for reappointment that do not limit the requested scope of practice privileges or category of appointment, such counseling or practice evaluation or other requirements do not constitute corrective action as defined in the *Bylaws of the Medical Staff*.

## **V. POLICY ON REAPPOINTMENT AND RENEWAL OF PRIVILEGES**

The procedures for processing initial applications and reappointment applications shall be the same as those described in OMSS 0001 policy.

	Policy Name	<b>Credentials Committee: Responsibilities &amp; Membership List</b>
	Policy Number	<b>OMSS 0021</b>
	Date this Version Effective	<b>April 2018</b>
	Responsible for Content	<b>Office of Medical Staff Services</b>

**I. DESCRIPTION**

This policy is about the role and responsibilities of the Credentials Committee members and Chair.

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**II. RATIONALE**

The Office of Medical Staff Services is responsible for providing support to the Chair of the Credentials Committee. The Credentials Committee is responsible for reviewing and giving thoughtful consideration of an applicant’s credentials before making recommendations about a practitioner’s ability to deliver patient care.

**III. POLICY**

**A. Committee Members**

The Credentials Committee consists of members of the Medical Staff and Allied Health Professionals appointed to ensure representation of the major clinical specialties, the Hospital-based specialties, the Medical Staff at large, and other personnel involved in the credentialing process. The size of the Committee shall be determined by the Chief of Staff with the approval of the Executive Committee.

**B. Meetings**

The Credentials Committee meets on a monthly basis or as needed to review applications for initial appointment, reappointment, and clinical privileges for Medical Staff and Allied Health Professionals at UNC Hospitals. The meetings will be held within a three year time period of the applicant’s appointment/reappointment dates.

**C. Role and Responsibilities of Committee Chair**

The Chair of the Credentials Committee has the authority to determine which files are “clean”, and to sign off on files as complete and clean. A “clean” file must meet the following criteria:

- No current challenge or a previously successful challenge to licensure or registration;
- No involuntary termination of medical staff membership at another hospital;
- No involuntary limitation, reduction, denial, or loss of clinical privileges; and/or
- No unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

The Chair, acting as designee for the Chief Medical Officer, may recommend approval of temporary privileges for a clean file. Any files that are reviewed and approved for temporary privileges by the Chair will be presented formally to the Credentials Committee at their next meeting for reaffirmation. The committee review date and the Chair's sign-off date are used to determine the timeliness of all requirements for credentialing.

#### **D. Role and Responsibilities of Committee Members**

UNC Hospitals' *Medical Staff Organization Manual of the Bylaws of the Medical Staff* outlines the following as key responsibilities of the Credentials Committee and its Chair:

1. To investigate the credentials of all applicants seeking appointment to the Medical Staff and to make written recommendations relative to membership and the delineation of clinical privileges to the Executive Committee;
2. To review all information available regarding the current competence of Medical Staff members, and to make recommendations relative to reappointment and renewal of clinical privileges;
3. To investigate any breach of ethics of which it becomes aware;
4. To investigate the credentials of all Independent and Dependent Allied Health Professionals and make recommendations for their scope of practice privileges; and
5. To review and approve credentialing policies and procedures as necessary, but at least annually.

The Committee reviews the practitioners' credentials and gives thoughtful consideration to the credentialing elements before making recommendations about a practitioner's ability to deliver care. Committee members defer any applications where members feel further clarification or investigation is warranted before they can recommend approval to the Executive Committee or where they feel the practitioner does not meet UNC Hospitals' established criteria.

A subcommittee of the Credentials Committee, the Emerging Technology Subcommittee, shall be appointed by the Chief of Staff to develop criteria and make recommendations for practitioners requesting clinical privileges to utilize emerging technologies such as robot-assisted surgery and cyberknife.

#### **E. Role and Responsibilities of the Office of Medical Staff Services**

The Office of Medical Staff Services supports the Chair and the members of the Credentials Committee.

##### **Annual/Ongoing Basis:**

1. The **Director/Manager of Medical Staff Services or designee:**
  - develops the annual meeting schedule, based on the meeting dates of the Executive Committee of the Medical Staff and Board of Directors;
  - in conjunction with the Chair, develops the meeting agendas;
  - attends all Credentials Committee meetings and takes/prepares the minutes;
  - compiles data for the Annual Report of the Credentials Committee for submission to the Chief of Staff;
  - prepares any other projects/reports as requested by the Chair of the Credentials Committee;
  - scheduling a location for the meetings; and
  - sending out the annual meeting schedule to all Committee members.

**Monthly - Prior to Credentials Committee Meeting:**

1. The **Credentialing Specialist:**
  - give complete files to the Director to review;
  - follows up on any missing items identified by the Director prior to taking file to meeting.
  - enters outlier data into Echo system;
  - uploads all complete initial appointment application files for review at the meeting;
  
2. The **Manager of Medical Staff Services:**
  - Reviews complete files; determines whether a file meets the credentialing requirements and will require review and approval of temporary privileges by the Chair prior to the next scheduled Credentials Committee meeting;
  - emails reminder memo, agenda, and minutes (1 week prior to the meeting) to members of the Committee and keeps track of the RSVP list for meetings;
  - following review by the Director, prepares the ballot of complete applications (includes any applications that have already been reviewed by the Chair and granted administrative approval);
  - uploads outlier information for review at the meeting;
  - provides final summary of Credentials Ballot to Chair prior to meeting;
  - copies the ballot, agenda and any handouts to take to the meeting;
  - attends the meeting and takes the minutes;
  - assures Chair has signed and completed the master ballot by indicating the Committee's decision by the name of each applicant;
  - collects all meeting handouts from members, takes back to office to file and/or shred.

**Monthly - After the Credentials Committee Meeting:**

1. The **Manager of Medical Staff Services:**
  - adds the master ballot completed/signed by the Chair of the Credentials Committee with the outlier information and any other meeting materials for "Credentials Committee" to the electronic notebook;
  - based on the outcome of the Credentials Committee decisions for each applicant, prepares a ballot of complete applications for review by the Medical Staff Executive Committee (MSEC), indicating which applicants met the criteria for expedited credentialing and those applicants that did not meet the criteria (*\*see Medical Staff Bylaws, Article VII for specific criteria*);
  - emails ballot to the Chief of Staff's Executive Assistant for review and recommendation by the MSEC at their next meeting;
  - transcribes the minutes for distribution with the next meeting's agenda.
  
2. The **Credentialing Specialist:**
  - sends email list of new (approved) applicants and any with changes to staff category to various areas within the Healthcare System; and
  - prepares temporary privileges letters, adds copy to file; and emails copy to Department Credentials Coordinator for distribution to provider; and
  - updates each new (approved) applicant's record in ECHO.

**Monthly – Day After the Executive Committee Meeting:**

1. The **Director of Medical Staff Services or designee:**
  - confirms with Chief of Staff's office whether or not individuals on the ballot were recommended for approval at the MSEC meeting; informs Director when received;
  - stores confirmation in electronic notebook;

- based on the MSEC recommendations and Director’s guidance - prepares the ballot of applications for review by either the Board of Directors’ Credentialing Subcommittee (for those applicants who meet the criteria for expedited credentialing) or for review by the Full Board of Directors (for those applicants who did not meet the criteria for expedited credentialing); and
- emails the ballot(s) to members of the Subcommittee or Full Board for review/approval.

**Monthly - After the Healthcare System Credentialing Subcommittee (Board of Directors) Meeting:**

1. The **Director of Medical Staff Services or designee:**
  - monitors receipt of Board’s decision;
  - files original ballot and Board members responses in the “Ballots” electronic notebook;
  - emails letter to Department Credentialing Coordinator;
2. The **Credentialing Specialist**
  - updates all applicant data in computer system (Echo) for each individual on the Board ballot;
  - generates the appointment/reappointment approval letters to the applicants, within 10 business days of approval; and
  - stores the file electronically in Echo Credentialing System.


**F. Membership List**

The Credentials Committee consists of members of the Medical Staff and Allied Health Professionals appointed by the Chief of Staff to ensure representation of the major clinical specialties, the Hospital-based specialties, the Medical Staff at-large, and other personnel involved in the credentialing process.

Administration/Legal Services	Sarah Fotheringham, J.D. Glenn George, J.D.
Anesthesiology	Ann Bailey, MD
Dentistry	Michael Roberts, D.D.S.
Dermatology	Vacant
Emergency Medicine	Abhi Mehrotra, M.D.
Family Medicine	Margaret R. Helton, M.D.
Internal Medicine	E. Allen Liles, Jr., M.D. C. Thomas Nuzum, M.D. Betsy Shilliday, CPP
Medical Staff Services	Linda Waldorf, CPMSM Phyllis Burke, CPCS
Neurology	J. Dedrick Jordan, M.D.
Neurosurgery	Sivakumar Jaikumar, M.D.
Obstetrics and Gynecology	M. Christina Munoz, M.D.

Ophthalmology	Vacant
Oral and Maxillofacial Surgery	Timothy A. Turvey, D.D.S.
Orthopaedics	J. Megan Patterson, M.D.
Otolaryngology, Head/Neck Surgery	Trevor Hackman, M.D.
Pathology and Laboratory Medicine	Herbert Whinna, M.D.
Pediatrics	Jenny Melissa Boyd, MD (Committee Chair) Carl Seashore, M.D.
Physical Medicine and Rehabilitation	Paul Thananopavarn, M.D.
Psychiatry	Mary Claire Kimmel, MD
Radiation Oncology	Ellen L. Jones, M.D.
Radiology	Charles Burke, M.D.
Surgery	Elizabeth B. Dreesen, M.D.

## Office of Medical Staff Services Manual

	Policy Name	<b>Privileges: Acupuncture For Non-Physician Providers</b>
	Policy Number	<b>OMSS 0026</b>
	Date this Version Effective	<b>January 2018</b>
	Responsible for Content	<b>Office of Medical Staff Services</b>

### **POLICY**

Only those providers who have applied and been authorized by the UNC Health Care System Board of Directors (upon recommendation by the Credentials Committee and Executive Committee of the Medical Staff) shall be permitted to perform acupuncture privileges at UNC Hospitals. The Office of Medical Staff Services is responsible for processing all initial requests and requests for renewal of acupuncture privileges.

Acupuncture privileges for physicians are currently a part of the clinical privileges request form for the Department of Family Medicine and the Department of Physical Medicine and Rehabilitation, thus it is not necessary to apply separately for these privileges. Non-physician providers on the Independent or Dependent Allied Health Professional staff are eligible to apply for acupuncture privileges, so long as they meet the minimum criteria.

### **PROCEDURE**

1. The **non-physician applicant** must meet the following eligibility requirements in order to apply for and receive acupuncture privileges:
  - a) Must hold a valid and current North Carolina Acupuncture License;
  - b) Must have successfully completed a three-year postgraduate acupuncture college or training program approved by the North Carolina Acupuncture Licensing Board; and
  - c) Must have completed and passed the NCCA (National Commission for the Certification of Acupuncturists) and PEPLS (Practical Examination of Point Location Skills) exams, as required by the NCALB.
2. The **applicant** must submit to his/her Departmental Credentialing Coordinator the following items that make up an initial request for acupuncture privileges packet:
  - a) Completed, signed/dated "Acupuncture Privileges Request Form" (see attached);
  - b) Letter to his/her Department Chair outlining the elements of his/her training and experience that meet the above eligibility requirements;
  - c) Copies of documentation of his/her training and/or experience that support this request.
3. The **Departmental Credentialing Coordinator** is then responsible for having the Department Chair review the acupuncture privileges request packet, and for having the Department Chair sign the request for privileges indicating his/her approval.
4. The **Departmental Credentialing Coordinator** is then responsible for submitting the acupuncture privileges request packet to the Office of Medical Staff Services for processing.
5. Following review by the Credentials Committee, the OMSS will notify the applicant of the Committee's decision.
6. Renewal of these privileges will be considered as part of the applicant's next reappointment.

## Office of Medical Staff Services Manual



Policy Name	<b>Privileges: Laser</b>
Policy Number	<b>OMSS 0028</b>
Date this Version Effective	<b>October 2017</b>
Responsible for Content	<b>Office of Medical Staff Services; Environmental Health and Safety; Laser Safety Subcommittee</b>

### POLICY

Only those providers who have been authorized by the UNC Health Care System Board of Directors (upon recommendation by the Credentials Committee and Executive Committee of the Medical Staff) shall be permitted to provide laser therapy or supervise laser therapies. As tissue effects, delivery methods and safety precautions vary greatly among laser systems, it is necessary to receive training specific to each laser wavelength before including alternate wavelengths in standard operating practice.

(\*see *UNC Healthcare Policies – EHS 0070 “ Provider Credentialing for Laser Use*)

### PROCEDURE

- I. The Applicant should complete, sign/date the Clinical Privileges Request Form for Lasers and Light Therapy Devices and submit it to their Departmental Credentialing Coordinator, along with the following:

#### A. NEW PRIVILEGES

1. 100% correct answers on LMS module

#### And, one of the following:

2. Written documentation from residency director of laser training specific to the specialty (if within two years), or
3. Written documentation of laser privileges in good standing from an accredited institution/current affiliation, or
4. Written documentation from UNC Health Care laser safety officer of laser training specific to the specialty.

#### B. RENEWAL OF PRIVILEGES

1. 100% correct answers on LMS module


#### C. NEW LASER PROCEDURE – introduction of a new laser procedure, not previously done at UNC Hospitals requires approval from the Laser Safety Committee

- II. The Departmental Credentialing Coordinator will then have the Department Chair review the documentation and requested privileges. Department Chair must sign all requests for laser privileges, thus indicating his/her approval.
- III. The Departmental Credentialing Coordinator will then submit the materials to the Centralized Credentialing Office for processing. The laser request will be presented to the full Credentials Committee.



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- IV. Once laser privileges are granted, renewal of these privileges will be considered as part of the reappointment process.
  - V. Following review by the Credentials Committee, OMSS will notify the applicant of the Committee's decision.
  - VI. Renewal of these privileges will be considered as part of the reappointment process.
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## Office of Medical Staff Services Manual

	Policy Name	<b>Privileges: Modification (Privileges/Staff Category/Department)</b>
	Policy Number	<b>OMSS 0029</b>
	Date this Version Effective	<b><i>January 2018</i></b>
	Responsible for Content	<b>Office of Medical Staff Services</b>

### **POLICY**

A staff member may, at any time, request modification of his/her Medical Staff category or clinical privileges by submitting to the Department Chair a written application on the prescribed form. Such application is processed by the Office of Medical Staff Services pursuant to the procedures set forth in the Bylaws of the Medical Staff.

### **PROCEDURE**

The Office of Medical Staff Services is responsible for processing all requests for modification of Medical Staff category and/or clinical privileges. All requests must be submitted by the Departmental Credentialing Coordinator for the clinical department the applicant is assigned to. The following documentation should be submitted:

#### ***For Change in Staff Category:***

1. Letter from applicant requesting and specifying type of change (if applicable)
2. Letter from applicant's Department Chair requesting and approving the change
3. Updated clinical privileges request form, if applicable

#### ***For Change in Department Assignment or Joint Department Assignment:***

1. Letter from applicant requesting change and specifying departments involved (if applicable)
2. Letter from applicant's Department Chair requesting and approving the change
3. For Joint Department Assignment, letter from both the current Department Chair and the additional Department Chair requesting and approving the joint assignment
4. Updated clinical privileges request form or job description/practice privileges (for AHPs)
5. Relevant information concerning training, experience, certification, etc.

#### ***For Change in Clinical Privileges:***

1. Letter from applicant requesting change or additional clinical privileges (if applicable)
2. Letter from applicant's Department Chair requesting and approving the change
3. Updated clinical privileges request form or job description/practice privileges (for AHPs)
4. Relevant information concerning training, experience, certification, etc.

When privileges are granted in a field outside of a practitioner's Board certification or eligibility, or in addition to the original scope of privileges granted, it is required to document the practitioner's education, training and current competence to perform the privilege(s) requested.


Upon receipt by the OMSS of a request for modification in a practitioner's Medical Staff category and/or

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clinical privileges, the Credentialing Specialist is responsible for the following:

1. Reviews requests for modification in appointment or privileges to determine if request meets the above stated policy.
2. Completes checklist for "Change in Appointment or Privileges". Also queries the NPDB, verifies current licensure, and performs other required verifications.
3. Once application is complete, gives file to the **Director of Medical Staff Services** for review prior to submitting it to the Credentials Committee for review.
4. OMSS adds request for modification in category and/or privileges to the ballot of acceptable/complete applications. The Credentials Committee reviews requests every month, or as needed, and makes their recommendation to the Executive Committee of the Medical Staff (per *Bylaws*).
5. Based on the outcome of the Credentials Committee, the Credentialing Specialist prepares the ballot for the Executive Committee's review. The Executive Committee reviews the Credentials Committee's recommendations monthly, and makes their recommendation to the UNC Health Care System Board of Directors (per *Bylaws*).
6. Based on the outcome of the Executive Committee, the **Director** prepares the ballot for the Board of Director's review. The Board of Directors reviews the Executive Committee's recommendations and approves (per *Bylaws*).
7. The **Credentialing Specialist** prepares letters of approval for the requested modification of appointment or privileges for signature by the President of UNC Hospitals.
8. The **Credentialing Specialist** is responsible for updating and distribution of information, as appropriate:
  - a. SER Table
  - b. Echo Credentialing System (including Privilege Portal)
9. The **Credentialing Specialist** is responsible for uploading packet to Echo:
  - a. Copy of Letter of Approval
  - b. Written request from the applicant and Department Chair(s)
  - c. Clinical Privileges Request Form(s)
  - d. Documentation supportive of the request.
  - e. NPDB Query Response
  - f. Current licensure verification

## Office of Medical Staff Services Manual

	Policy Name	<b>Privileges: Sedation (Adult &amp; Pediatric)</b>
	Policy Number	<b>OMSS 0030</b>
	Date this Version Effective	<b>January 2018</b>
	Responsible for Content	<b>Office of Medical Staff Services</b>

### POLICY

The intent of this policy is to provide a consistent standard of care throughout the Hospitals and Ambulatory Care Clinics for the management of patients receiving sedation/analgesia when undergoing therapeutic or diagnostic procedures. The policy is not intended as a standard order, or to replace clinical judgment, but shall be considered minimum requirements when sedative medications are used.

*\*see UNC Healthcare – Administrative Policy Manual*


- ADMIN 0212: Pediatric Sedation Policy for Non-Anesthesiologists;
- ADMIN 0160: Moderate (Adult) Sedation for Non-Anesthesiologists;
- ADMIN 0215: Deep (Adult) Sedation for Non-Anesthesiologists

### PROCEDURE

OMSS includes with each initial appointment and reappointment application packet a “Sedation Privileges Request Form” with instructions/checklists on how to apply for sedation privileges.

1. The **applicant** must complete the appropriate sedation requirements checklist for the specific type of sedation privileges being requested (i.e. adult moderate, adult deep, pediatric).
2. The **applicant** should attach all the supporting documentation and checklist(s) to the “Sedation Privileges Request Form”, sign/date the form(s), and submit packet to their Departmental Credentialing Coordinator.
3. The **Departmental Credentialing Coordinator** should check to be sure all the required documentation has been attached to the “Sedation Privileges Request Form”.
4. The **Department Credentialing Coordinator** then forwards packet to the Department Chair for review and signature.
5. The **Departmental Credentialing Coordinator** is then responsible for submitting the sedation privileges request packet to the Office of Medical Staff Services for processing.
6. Requests for “pediatric sedation” are forwarded to Dr. Jenny Boyd for review/approval prior to presentation to the Credentials Committee. Requests for “adult deep” are forwarded to Dr. Michael Harrigan for review/approval prior to presentation to the Credentials Committee.
7. Following review by the Credentials Committee, the OMSS will notify the applicant of the Committee’s decision.
8. Renewal of these privileges will be considered as part of the applicant’s next reappointment.

## Office of Medical Staff Services Manual

	Policy Name	<b>Privileges: Trauma Team Leader</b>
	Policy Number	<b>OMSS 0032</b>
	Date this Version Effective	<b>January 2018</b>
	Responsible for Content	<b>Office of Medical Staff Services</b>

### POLICY

Individuals leading the UNC Hospitals' Level I Trauma Center Trauma Team shall be physician members of the staff of UNC Hospitals and hold an appointment as a faculty member in the University of North Carolina School of Medicine. Trauma Team Leaders shall be Board certified or Board eligible. In addition, these physicians should have manifested sufficient interest in trauma care such that they have received additional education in the form of trauma fellowships (or a recognized substitute such as military service) or certification of additional education in critical care and/or advanced trauma life support.

Appointment to the Trauma Team will be by the Chairman of the Department of Surgery and in conjunction with the Chief of the Trauma/Critical Care Division.

### Responsibilities of Trauma Team Leaders

Trauma Team Leaders at UNC Hospitals will be responsible for fulfilling the requirements set forth by the American College of Surgeons for leadership of a Level I Trauma Center Team. Trauma Team Leaders will oversee the care of patients with multi-system and/or life or limb threatening injuries and coordinate consultations, as necessary, by specialists in neurosurgery, orthopaedics, plastic surgery, etc. Trauma Team patients include those with severe injury to one body system and strong suspicion of involvement of a second system as well as critically injured or unstable trauma patients with the involvement of one system. The Emergency Department physician and/or the first Trauma Team Leader on site shall evaluate and initiate resuscitation. Each Trauma Team Leader shall be able to apply or oversee the use of the following equipment for resuscitation and life support:

1. Airway control and ventilation equipment including laryngoscopes and endotracheal tubes of all sizes, bag-mask resuscitator, pocket masks, oxygen, and mechanical ventilator.
2. Suction devices.
3. Electrocardiograph-oscilloscope-defibrillator.
4. Apparatus to establish central venous pressure monitoring.
5. All standard intravenous fluids and administration devices including intravenous catheters.
6. Sterile surgical sets for procedures standard for Emergency Department, such as thoracostomy, cut-down, etc.
7. Gastric lavage equipment.
8. Drugs and supplies necessary for emergency care.
9. Skeletal traction device for cervical injuries.

The Medical Director of the Trauma Team must be a General Surgeon who is an expert in and committed to the care of the injured. The Director will be responsible for the organization and direction of the entire Trauma Team according to the standards set forth by the American College of Surgeons.

## **PROCEDURE**

The Office of Medical Staff Services is responsible for processing all requests for appointment to the Trauma Team. The **Departmental Credentialing Coordinator** (DCC) is responsible for obtaining and submitting the above documentation to the OMSS for processing.


All applicants must submit the following documentation for consideration:

1. A letter from the applicant requesting appointment to the Trauma Team.
2. A letter from the Department Chair recommending appointment to the Trauma Team.
3. Documentation or certification supportive of the request.
4. Current curriculum vitae.
5. A completed Trauma Team Privilege Request Form signed by both the applicant and the Department Chair (and Chief of Neurosurgery, if applicable)

Upon receipt by the OMSS of a request for Trauma Team privileges, the **Credentialing Specialist** is responsible for the following:

1. Reviews the documentation for completeness and completes the checklist.
2. Verifies current licensure, queries the NPDB and obtains any other required verifications.
3. The **Director of Medical Staff Services** reviews all requests and request is added to the Credentials Committee ballot.. The Credentials Committee reviews requests for Trauma Team privileges monthly, and makes their recommendation to the Executive Committee of the Medical Staff.
4. The **Credentialing Specialist** prepares ballot for the Executive Committee's review. The Executive Committee reviews the Credentials Committee's recommendations monthly, and makes their recommendation to the UNC Health Care System Board of Directors.
5. The **Director of Medical Staff Services** prepares ballot for the Board of Directors' review. The Board of Directors reviews the Executive Committee's recommendations monthly, and approves.
6. After approval by the Board of Directors, the **Credentialing Specialist** prepares letters to the physicians notifying them that their request for Trauma Team privileges was approved. These letters are signed by the President of UNC Hospitals.
7. After the approval letters have been signed by the President, the **Credentialing Specialist** distributes the letter and uploads copy to file.
8. The **Credentialing Specialist** updates information in:
  - a. Status Checklist in Physician's File
  - b. Echo Credentialing System
9. Requests for renewal of Trauma Team privileges occur at the time of the applicant's reappointment. The applicant and Chair must complete an updated Trauma Team Privilege form.

## Office of Medical Staff Services Manual

	Policy Name	<b>Privileges: Cyberknife or Linac-based Radiosurgery</b>
	Policy Number	<b>OMSS 0033</b>
	Date this Version Effective	<b>January 2018</b>
	Responsible for Content	<b>Office of Medical Staff Services; Emerging Technology Credentials Subcommittee</b>

### **POLICY**

Only those physicians who have applied and been authorized by the UNC Health Care System Board of Directors (upon recommendation by the Credentials Committee and Executive Committee of the Medical Staff) are permitted to perform Cyberknife or Linac-based radiosurgery. The Emerging Technology Credentials Subcommittee reviews all applications for Cyberknife or Linac-based radiosurgery privileges and makes a recommendation to the Credentials Committee regarding approval. The EMTCS also is responsible for policies and procedures for Cyberknife or Linac-based radiosurgery at UNC Hospitals.

**This policy applies only to Medical Staff OUTSIDE OF the Department of Radiation Oncology, as radiation oncologists are exempt based on their education/training.**

### **PROCEDURE:**

#### **Initial Privileges:**

1. The applicant must complete, sign, and date the Cyberknife or Linac-based Radiosurgery Privileges Request form and submit it to his/her Departmental Credentialing Coordinator, along with documentation of eligibility to receive Cyberknife or Linac-based radiosurgery privileges. The requirements for eligibility for initial privileges are:

- Must be board certified or board eligible within his/her surgical specialty.
- Must participate in NC Clinical Cancer Center Clinical activities unless treating benign/non-cancerous conditions (e.g. arteriovenous malformations).
- Must have completed Accuray-sponsored technical training course;

**- OR -**

Must show evidence of attendance at a hands-on training practicum in the use of Cyberknife stereotactic radiosurgery treatment planning system for at least 5 cases with supporting documentation (i.e., brief operative note) of performing the treatment planning procedure including the following components: image registration, contouring, target delineation, treatment planning, treatment evaluation, alignment and understanding of tracking system that will be utilized,

**- OR -**

Demonstrate formal training in residency or fellowship with the Cyberknife stereotactic radiosurgery system, or similar Linac-based training.

- Must show evidence of observing at least 2 additional clinical cases utilizing the Cyberknife Radiosurgery System and tracking methods for treatment delivery.
- Must show evidence of satisfactorily completing 5 cases (can be the same as the hands-on training practicum) with an authorized user in radiation oncology if the technical training course is not completed.


- Must commit to being present for the key components of treatment plan development and readily accessible (or have a colleague in his/her specialty readily accessible) to address medical or surgical problems that might arise during delivery of Cyberknife or similar Linac-based treatment.
2. The Applicant must send a letter to his/her Chair outlining the elements of his/her training and experience that meet the above requirements, and this letter must be included with the application for privileges.
  3. The Departmental Credentialing Coordinator must have the Department Chair review the documentation and requested privileges and sign the request for privileges indicating his/her approval.
  4. The Departmental Credentialing Coordinator must submit the materials to the Office of Medical Staff Services for processing. The request will be forwarded to the Chair of the Emerging Technology Credentials Subcommittee for his review and recommendation prior to presentation to the Credentials Committee.
  5. Following review by the Credentials Committee, OMSS will notify the applicant of the Committee's decision.
  6. Once cyberknife radiosurgery privileges have been granted, future renewals of these privileges will be considered as part of the reappointment process. Requests for renewal must be approved by the Emerging Technology Credentials Subcommittee prior to presentation to the Credentials Committee.

**For Reappointment of Privileges:**

For renewals, providers must have had experience with at least 5 cases in the prior two years. If they do not have at least 5 cases in the prior two years, the provider must perform two proctored cases prior to performing cases independently.



## Office of Medical Staff Services Manual

	Policy Name	<b>Privileges: Robotic Surgery</b>
	Policy Number	<b>OMSS 0034</b>
	Date this Version Effective	<b>January 2018</b>
	Responsible for Content	<b>Office of Medical Staff Services; Emerging Technology Credentials Subcommittee</b>

### POLICY

Only those physicians who have been authorized by the UNC Health Care System (“UNC HCS”) Board of Directors (upon recommendation by the Credentials Committee and Executive Committee of the Medical Staff of UNC Hospitals) shall be permitted to perform or supervise robot-assisted surgery. The Emerging Technology Credentials Subcommittee reviews all applications for robotic surgery privileges and makes a recommendation to the Credentials Committee regarding approval. The EMTCS is also responsible for policies and procedures for robot-assisted surgery equipment use at UNC Hospitals.


Surgeons interested in Robotics are **REQUIRED** to meet with the Computer and Robotic Enhanced Surgery (“CARES”) Center Program Coordinator prior to attending any training courses with Intuitive Surgical. Items to be discussed are: 1) Robotic Credentialing Guidelines and 2) Robot Scheduling Protocol at UNC Hospitals.

### PROCEDURE

1. An Applicant for robotic surgery privileges must complete the separate “Clinical Privileges Request Form for Robot-assisted Surgery” and submit it to his/her Departmental Credentialing Coordinator, along with documentation of eligibility to receive robot-assisted surgery privileges. The requirements for eligibility are:
  - Must be board certified or board eligible within his/her surgical specialty; and
  - Must be eligible to be credentialed at UNC Hospitals in laparoscopic/endoscopic surgery; and
  - Must meet training and experience requirements:
    - a) Must have completed a three-hour hands-on system overview given by an Intuitive Surgical representative or certified UNC School of Medicine Faculty (or equivalent at a comparable medical institution) plus the web-based Intuitive course;  
**- OR -**
    - b) Must show evidence of attendance at an eight-hour hands-on training practicum in the use of the da Vinci® surgical platform. Must have three hours of personal time on the system during this training; and
  - Must show evidence of observing at least two clinical cases utilizing the da Vinci® Surgical System; and
  - Must show evidence of satisfactorily completing:
    - a) two proctored patient cases on the da Vinci® Surgical System within 12 months of completing the da Vinci® course;  
**-OR -**
    - b) four proctored cases within 12 months of completing the UNC HCS hands-on course (or equivalent).

2. The Applicant must have the Proctoring Surgeon complete the Robot Proctorship Form (attached) after each proctored case, and the Applicant must submit it with his or her credentialing documents.
  - a) If the Applicant does not complete the requisite number of proctored cases within 12 months of completion of training, the Applicant must repeat the training.
  - b) Provisional robotic-assisted surgery privileges can be provided to an Applicant who learned the use and application of the da Vinci® Surgical System during residency or fellowship training if the Applicant has a letter from the Department Chair or Residency Program Director at the Applicant's training institution stating the Applicant's proficiency. The letter should indicate the elements of training and experience that meet the above criteria.
  - c) If a surgeon comes to UNC HCS with prior training and experience, such as training obtained at another institution, and currently is privileged to perform robotic cases at another Joint Commission-accredited facility and has performed a minimum of 12 robotic cases in the prior 12 months, he or she may be granted initial privileges without undergoing proctored cases.
3. The Departmental Credentialing Coordinator must have the Department Chair review the Applicant's documentation and requested privileges and sign the attached Clinical Privileges Request Form for Robotic Surgery privileges, indicating his/her approval.
4. The Departmental Credentialing Coordinator must submit the materials to the Office of Medical Staff Services for processing. The request will be forwarded to the Chair of the Emerging Technology Credentials Subcommittee for his or her review and recommendation prior to presentation to the Credentials Committee.
5. Following review by the Credentials Committee, the Office of Medical Staff Services will notify the Applicant of the Committee's decision.
6. Once robotic surgery privileges are granted, future renewals of these privileges will be considered every two years as part of the reappointment process. Requests for renewal must be approved by the Chair of the Emerging Technology Credentials Subcommittee prior to presentation to the Credentials Committee.

## Office of Medical Staff Services Manual

	Policy Name	<b>American Medical Association, American Osteopathic Association: - Physician Profile - Physician Assistant Profile</b>
	Policy Number	<b>OMSS 0036</b>
	Date this Version Effective	<b><i>January 2018</i></b>
	Responsible for Content	<b>Office of Medical Staff Services</b>

### POLICY

The Office of Medical Staff or Centralized Credentialing Office will query the American Medical Association Physician Profile for MDs, the American Osteopathic Association Physician Profile for DO's, and the Physician Assistant Profile for all PAs that are applying for initial appointment.

The AMA Physician Profile and AOA Physician Profile meets the primary source requirements set forth by the Joint Commission, NCQA, and other agencies for the following:


- Medical/Osteopathic School and date of graduation
- Residency training history – ACGME and specialty board-approved combined residency programs
- Current and historical state licensure – includes current status and expiration date
- Current and historical ABMS board and sub-board certification – includes expiration dates
- DEA status
- Sanctions taken by state medical boards, Medicare, Medicaid, and other federal agencies – lists a contact for more information
- National Board of Medical Examiners Certification year
- AMA Physician Recognition Award Certificate recognizing at least 50 hours of CME

NOTE: If the AMA does not contain verification of all required information, then the primary source is contacted directly for the verification either online or in writing.

The AMA Physician Assistant Profile meets the primary source requirements set forth by the Joint Commission, NCQA, and other agencies for the following:

- Physician Assistant education programs, including graduation date;
- Current and historical physician assistant state licensure;
- National Commission on the Certification of Physician Assistants, including NCCPA number and status;

## Office of Medical Staff Services Manual

	Policy Name	<b>Credentialing Information: Confidentiality and Protection</b>
	Policy Number	<b>OMSS 0038</b>
	Date this Version Effective	<b>January 2018</b>
	Responsible for Content	<b>Office of Medical Staff Services</b>

### POLICY

UNC Hospitals recognizes its obligation to safeguard the confidentiality and integrity of Medical Staff records (which includes, but is not limited to, credentials files, microfilm, meeting minutes, FPPE/OPPE, outlier review activity data, and electronic databases) against disclosure or use by unauthorized individuals. The Hospital will treat the credentials file and any information secured in connection therewith in strict confidence, preserving with all reasonable safeguards the privacy of the applicant.

### PROCEDURE

#### Office Security & Physical Access

The Office of Medical Staff Services and Centralized Credentialing Office (CCO) is located off-site from the main Hospital. The office suite is located on the 2<sup>nd</sup> floor of the building in an area that can only be reached via an employee security access card. Visitors to OMSS/CCO must use an intercom and an OMSS staff member must open the locked door to gain entry. Additionally, the Timberlyne Office Building is equipped with security cameras and security monitors.

All Medical Staff records shall be maintained in the Office of Medical Staff Services and Centralized Credentialing Office under the care and custody of the Director of OMSS and CCO. The OMSS/CCO shall be kept locked after normal office hours, or when no OMSS/CCO staff are present. Credentials files are kept in file cabinets, which are locked after office hours or when OMSS/CCO staff are not present. Microfilmed credentials files are kept in locked storage cabinet.

Meeting minutes, outlier activity data, and other documentation related to discussions and/or deliberations regarding credentialing, quality assessment, and peer review matters are maintained in the Director or the Peer Review Specialists' offices, which are kept locked when they are not in.

1. The Director, CCO and OMSS staff will safeguard to the best of their ability their Hospital photo identification badge (which also serves as their security access card to this office building), as well as their keys to the OMSS/CCO. During office hours, individuals visiting this office gain entry by speakerphone from the main entrance before being allowed to enter.
2. The Director, CCO and OMSS staff are responsible for making sure that the file cabinets and other confidential materials are secured for after-hours, or at any time a staff member is not present in the office during regular office hours.
3. The Director, CCO and OMSS staff will be provided with their own unique user ID and passwords by the Hospitals' Information Services Department. Electronic Medical Staff data is maintained in two databases, which only can be accessed by providing a unique user ID and password. Staff are to exit the database when not in use or they are away from their desk in order to prevent confidential information from being displayed and viewed by unauthorized individuals.

## **Access to Medical Staff Records**

Written consent by the practitioner is required for release of credentials information to persons outside the hospital or not otherwise authorized to receive such information. This includes the various managed care organizations that have delegated credentialing agreements with the Hospital and UNC Physicians and Associates as part of their contract. Only those persons directly involved in the credentials process or those performing official hospital/medical staff functions shall have access to the credentials file and information secured in connection therewith, unless the practitioner has provided their written consent.

1. **Outside Verification Requests:** For providers, not in good standing, requests from outside agencies for verification of a practitioner's past/current hospital affiliation with this hospital must contain a copy of a signed release from the practitioner authorizing the OMSS to provide such data. OMSS staff are responsible for ensuring such release is present with all requests and for obtaining one from the agency if one was not provided. No verifications will be provided until a release is obtained.

Telephone requests for verification of a past/current affiliation with this hospital are limited to either a "yes" or "no" response as to whether a practitioner is/was affiliated at our hospital. Requests for more specific information are not provided by phone without a copy of a signed release being provided by the agency from the practitioner authorizing the OMSS to provide such data. For providers who are in good standing or left in good standing, all agencies are referred to NAMSS PASS, a secure primary source database.

2. **Audits:** Practitioners credentials files that are selected for audit by an MCO must contain the practitioner's written consent for inspection. OMSS staff are responsible for reviewing all files selected for audit to assure that consent is present in the file. If the consent is not present, or if the practitioner has indicated "no", the Credentialing Specialist contacts the practitioner to notify him/her of the possible consequences for not consenting to audit of their file. The MCO may elect to discontinue a non-consenting practitioner as a provider in their plan. Auditors are required to sign "UNC Hospitals' Confidentiality Agreement" prior to each audit.
3. **Surveys:** Representatives of regulatory or accreditation agencies (i.e. Joint Commission, DFS) may have access to Medical Staff records while at UNC Hospitals as part of the accreditation survey process. MCO's undergoing a NCQA accreditation survey will be provided a copy of credentials files as part of their delegated credentialing agreement with UNC Hospitals and UNC Physicians and Associates. Upon completion of the survey, MCO's are asked to destroy by shredding the files copied.
4. **Rosters:** The OMSS does not provide rosters of its Medical Staff to outside agencies. This is to protect them from unsolicited contact by outside vendors. The OMSS will distribute on an annual basis a directory of physicians to individuals within the Hospital and Medical School only.
5. **Practitioners:** Any practitioner who wants to review his/her credentials file must submit a written request to the OMSS to arrange a time to meet with either the Director or a designee. Requests for file review must be received by the OMSS at least one working day in advance. The practitioner may not view his file without the Director or designee being present.

Prior to the meeting, the Director or designee shall remove any documentation that was not directly provided by the practitioner or is confidential (i.e. references, evaluations, outlier data, etc.). Requests by the practitioner to view any of the confidential information shall have to be approved by the Hospital Attorney.


The practitioner may only be provided with copies of documentation that he/she originally provided (i.e. application, clinical privileges request form, DEA certificate, license, etc.) or other non-confidential documents submitted by outside sources. Confidential documentation obtained as part of the credentialing/recredentialing process may not be copied.

6. **Persons Performing Official Hospital or Medical Staff Functions:** Medical Staff officers, Department Chairs, Credentials Committee members, members of the governing body, Hospital Attorneys, Hospital President, and consultants, may have access to medical staff records to the extent necessary to perform their official functions.

**HIPAA (Health Insurance Portability & Accountability Act)**

All UNC Health Care System and UNC School of Medicine employees, volunteers, students, staff and physicians are required to complete annual educational sessions about the HIPAA Privacy/Security regulations. The Office of Medical Staff Services will receive all such mandatory training and will abide by all applicable policies as outlined in the UNC Health Care System policies on HIPAA.

## Office of Medical Staff Services Manual

	Policy Name	<b>Criminal Background Checks</b>
	Policy Number	<b>OMSS 0040</b>
	Date this Version Effective	<b>January 2018</b>
	Responsible for Content	<b>Office of Medical Staff Services</b>

### POLICY


UNC Hospitals is required, as part of the credentialing process, to perform a complete “criminal history screening and check” for all physicians and non-physicians through FirstPoint Resources. Should an investigative report through FirstPoint Resources contain “adverse” information that is used in reaching a decision, UNC Hospitals is required to provide a copy of the report to the individual with a written description of the rights of the individual and a copy of “A Summary of Consumer Rights Under the Rights of Fair Credit Reporting Act”. The information from the investigative consumer report cannot and will not be used by UNC Hospitals in violation of any applicable Federal or State law or regulation. Prior to a CBC being performed, the OMSS must obtain and have on file a signed authorization from the practitioner.

### PROCEDURE

The **Credentialing Specialists** are responsible for the following:

1. Including a CBC authorization letter in each initial appointment and reappointment application packet.
2. Assuring that each practitioner has signed/dated the authorization letter upon its return to OMSS/CCO.
3. Submitting a CBC query for each applicant.
4. Submitting online query to FirstPoint Resources.
5. Go online to retrieve CBC profiles from FirstPoint Resources.
6. Reviewing CBC profile for any problems. Note receipt on file checklist and then place CBC profile in practitioner’s credentials file.
7. Giving any problematic CBC profiles to the Director of Medical Staff Services.
8. Sending to Department Chair for review any problems identified.

## Office of Medical Staff Services Manual

	Policy Name	<b>DEA Registration</b>
	Policy Number	<b>OMSS 0041</b>
	Date this Version Effective	<b>January 2018</b>
	Responsible for Content	<b>Office of Medical Staff Services</b>

### POLICY

North Carolina law requires that practitioners document their Federal DEA number on all prescriptions. Applicants for appointment and/or clinical privilege at UNC Hospitals should obtain their own DEA registration if their specialty requires that they write prescriptions in the course of their practice. Examples of physicians who may not require a DEA number are pathologists and radiologists.

Practitioners that are required to have a DEA must maintain a current DEA at all times.

For state employed practitioners, a fee-exempt DEA registration is valid regardless of the location in which the LIP provides services, so long as the LIP is acting within the scope of his or her official state duties and his or her direct compensation for such services is provided by a state agency (e.g., UNC Health Care System). The validity of this position has been confirmed with DEA's central office. (<http://news.unchealthcare.org/som-vital-signs/2012/may31/dea>)

### I. PROCEDURE

The **Credentialing Specialists** are responsible for the following with regard to maintaining information on and verification of a practitioner's DEA registration:

1. Reviewing the appointment or reappointment application to determine whether or not a practitioner has indicated if they have a current Federal DEA registration with a North Carolina address.
2. If the applicant has indicated he/she is registered with the DEA, then makes sure a copy of the certificate was provided, that the copy is legible, that the certificate is current, and reviews for any prescribing "restrictions". If any "restrictions" are noted, then additional documentation/explanation is obtained from the practitioner.
3. If the applicant has applied for DEA registration, then makes sure that "pending" has been indicated on the application. The CS monitors receipt and follows-up with the practitioner, as necessary.
4. If the applicant does not require registration with the DEA, then "NA" should be indicated on the application.
5. For practitioner's undergoing the appointment or reappointment process, verifies current DEA registration online via the National Technical Information Service (NTIS) database or DEA database. Reviews the profile for current drug schedules and expiration date. Initials, dates and places in the practitioner's file, along with a copy of the current certificate, if available.
6. For individuals not undergoing the initial appointment or reappointment process, monitors DEA registration information by generating monthly reports of individuals with DEA's due for renewal. Sends out monthly letter to applicants requesting copy of updated certificate.


Verifies current DEA registration online via the National Technical Information Service (NTIS)



database or DEA database. Views documentation, dates and initials. Reviews the profile for current drug schedules, any restrictions, and expiration date. Updates applicable fields in Echo and electronically stores the documentation.

7. Practitioners with an expired DEA shall be subject to automatic administrative action per Article VI, Section 3 b. of the Bylaws until a current DEA is received.

## Office of Medical Staff Services Manual

	Policy Name	<b>Licensure Requirements</b>
	Policy Number	<b>OMSS 0044</b>
	Date this Version Effective	<b>January 2018</b>
	Responsible for Content	<b>Office of Medical Staff Services</b>

### POLICY

Licensure requirements vary by practitioner type. Each applicant is responsible for applying, obtaining and maintaining, as appropriate, a current, unrestricted license in order to meet the criteria for appointment, reappointment, and/or privileges at UNC Hospitals.

#### Medical Staff:

##### Physicians:

NC Medical Board

<http://www.ncmedboard.org/>

- Acceptable types of NC medical licensure for appointment/clinical privileges at UNC Hospitals include: temporary, permanent, faculty limited license.
- A residency training license is not acceptable.

##### Dentists:

NC Board of Dental Examiners

<http://www.ncdentalboard.org/>

- Acceptable types of NC dental licensure for appointment/clinical privileges include: permanent or dental instructor.
- Those with a dental instructor license must also hold an active dental license in another state.

#### Independent Allied Health Professionals:

##### Acupuncturist:

NC Acupuncture Licensing Board

<http://www.ncalb.com/>

##### Clinical Pharmacist:

NC Board of Pharmacy

<http://www.ncbop.org>

##### Family & Marital Therapist:

NC Marriage & Family Therapy Licensure Board

<http://www.nclmft.org/>

##### Licensed Clinical Social Worker:

NC Social Work Certification & Licensure Board

<http://www.nccbsw.org/>

- Only those social workers that hold licensure at the L.C.S.W. level are eligible for appointment/privileges.

##### Optometrist:

NC Board of Optometry

<http://www.ncoptometry.org>

Podiatrist: NC Board of Podiatry Examiners  
<http://www.ncbpe.org>

Psychologist: NC Psychology Board  
<http://www.ncpsychologyboard.org/>

**Dependent Allied Health Professionals:**

Certified Registered Nurse Anesthetist NC Board of Nursing  
<http://www.ncbon.com/>

- Must maintain a current R.N. license; **AND**
- Must maintain current CRNA Recognition in NC; **AND**
- Must maintain current certification by the Council on Certification of Nurse Anesthetists (required in order to maintain current CRNA Recognition in NC).

*Per the NC Board of Nursing, the registered nurse who completes a program accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs, is credentialed as a **certified registered nurse anesthetist** by the Council on Certification of Nurse Anesthetists, and who maintains recertification through the Council on Recertification of Nurse Anesthetists, may perform nurse anesthesia activities in collaboration with a physician, dentist, podiatrist, or other lawfully qualified health care provider, but may not prescribe a medical treatment regimen or make a medical diagnosis except under the supervision of a licensed physician."*

Clinical Pharmacist Practitioner: NC Medical Board  
<http://www.ncmedboard.org/>

**AND** NC Board of Pharmacy  
<http://www.ncbop.org>

- Must maintain a current CPP license through the NC Medical Board; **AND**
- Must maintain a current Pharmacy license through the NC Board of Pharmacy, in addition to the CPP license.

Nurse Midwife: NC Board of Nursing  
<http://www.ncbon.com/>

- Must maintain a current R.N. license through the NC Board of Nursing; **AND**
- Must maintain current "approval to practice" as a CNM by the Joint Midwifery Committee of the NCBON; **AND**
- Must maintain national certification by the American College of Nurse Midwives.

Nurse Practitioner: NC Board of Nursing  
<http://www.ncbon.com/>

- Must maintain a current Nurse Practitioner license; **AND**
- Must maintain a current R.N. license through the NC Board of Nursing.

Physician Assistant: NC Medical Board  
<http://www.ncmedboard.org/>

- Must maintain a current Physician Assistant license through the NC Medical Board.


## PROCEDURE

1. The **Credentialing Specialist (CS)** reviews the appointment application to ascertain if applicant holds a license. If an applicant does not have a license at the time they submit an initial appointment application, then both the practitioner and their department are made aware of the fact that the application cannot be presented to the Credentials Committee until a license has been obtained. Also, applicants up for reappointment must hold a current license in order to be presented to the Credentials Committee. It is the responsibility of the practitioner to obtain a current, unrestricted license in order to obtain and maintain hospital appointment and privileges.
2. Once a license has been obtained, then the **Credentialing Specialist** queries the appropriate licensing Board to verify the license number, date it was granted, the expiration date, and if it has ever been revoked/suspended, and if there is a public file. This is accomplished via online web access with license board, telephone, fax, or in writing.
3. The **Credentialing Specialist** notes this verification information on the application status sheet and file checklist. Places the verification in the credentials file.
4. The **Credentialing Specialist** should update the license information in the following:
  - A. Echo Credentialing System
5. License expirations and renewals are monitored on an ongoing basis for applications in process, as well as those in between appointments. (*\* See also P&P – Ongoing Performance Monitoring*) Any sanctions or actions on a license are investigated. Copies of public files are obtained.

The **Credentialing Specialist** goes online to verify renewal. The individual's license profile is printed as verification of renewal. DataLINC is utilized for automatic notification that physician or physician assistant license has expired. The renewal is monitored until such time as it is verified that they have renewed. The final verification is also printed and placed with their others as documentation of verification. The verification is initialed and electronically stored in the credentials file.

6. **Departmental Credentialing Coordinators** are notified when an individual fails to renew their license. It is then their responsibility to contact their practitioner to determine the status of the renewal process and then report back to OMSS. Should the practitioner fail to renew their license and the licensure board makes it "inactive or revoked", then their Hospital appointment/privileges are also made inactive (administratively) until the matter is resolved with the appropriate licensure board. Once the practitioner has renewed their license and OMSS has been able to verify, then the practitioner's hospital appointment/privileges are made active again.
7. The **Credentialing Specialists or designee** review the disciplinary action reports for each licensure board every month, or as available. All individuals on the report are compared against the active list of practitioners at UNC Hospitals. Anyone that is identified as active at UNCH with an license action is investigated and documented in the file. (*\* See also P&P – Ongoing Performance Monitoring*) OMSS staff are immediately notified via email of any license revocations by the NC Board of Medical Examiners for M.D., C.P.P., D.O., P.A., or N.P. practitioners at UNC Hospitals. OMSS staff are also notified via email of any license action taken by the NC State Board of Dental Examiners.

## Office of Medical Staff Services Manual

	Policy Name	<b>Managed Care: Delegated Credentialing Agreements</b>
	Policy Number	<b>OMSS 0045</b>
	Date this Version Effective	<b>January 2018</b>
	Responsible for Content	<b>Office of Medical Staff Services</b>

### POLICY

UNC Hospitals has numerous managed care contracts, most of which have delegated credentialing agreements with the Hospital and UNCP&A. These delegated credentialing agreements require the Office of Medical Staff Services to comply with the following accreditation/regulatory bodies' credentialing standards: the National Committee for Quality Assurance (NCQA), the American Accreditation Healthcare Commission (URAC), the NC Department of Insurance (NCDOI), in addition to Joint Commission, CMS, and other regulatory/accreditation credentialing standards required by the Hospital. The managed care contracts and delegated credentialing agreements are handled by the UNCH Managed Care Office.

The delegated credentialing agreements allow for the managed care organizations (MCO) to perform annual "oversight" audit of UNC Hospitals' credentialing program by an auditor from each MCO. The auditor reviews credentials files, policies/procedures, minutes from the Credentials Committee meetings, and other documentation to assure compliance with the applicable credentialing standards.

In October 2001, the "Uniform Application to Participate as a Health Care Practitioner" was mandated by the NC General Assembly under House Bill 1160: Uniform Provider Credentialing. All managed care insurers are required to use this form. Therefore, the Office of Medical Staff Services has implemented use of this uniform application – **in addition** to our existing "Uniform Application for Medical/Allied Health Professionals" in order to be in compliance with our many managed care contracts. Use of both applications is necessary because the uniform application does not contain all of the elements required by The Joint Commission.

OMSS does **not** delegate any portion of the credentialing or recredentialing process to an outside agency.

### PROCEDURE

#### On-Site Audits

1. The MCO contacts the OMSS to schedule a convenient time for an onsite audit. The Director or Designee contacts the Director of Managed Care for UNC Hospitals to confirm that a contract is in place or is being negotiated with this particular MCO.

Any requested pre-audit documents, including but not limited to: OMSS Policies & Procedures, Medical Staff Documents – Instructions Sheet (that directs them to a UNCH website to view: Bylaws of the Medical Staff, Rules & Regulations of the Medical Staff, Medical Staff Organization Manual), UNC Liability Insurance Trust Fund Memorandum of Coverage, Sample Appointment and Reappointment Applications are provided to the auditor.

2. If this is a new delegation agreement, then a file is set up for the MCO.
3. The MCO must contact UNC Physicians & Associates Managed Care Office to obtain a master list of providers to randomly select files from.
4. Then the MCO is required to submit to the OMSS a list of files they are requesting to audit. The list should be submitted to the OMSS as soon as possible, but at least 2 weeks prior to the audit.

5. The Director of Medical Staff Services or Designee will go through 1-2 files in order to acquaint the auditor with how the files are arranged and where they should find the documentation, to answer any questions they may have as a result of their review of the pre-audit documentation, and also get a signed “Confidentiality Statement” to be placed in the contract file. At the conclusion of the audit, the Director or Designee will again meet with the auditor to answer any questions that may have arisen as a result of their review.
6. Following the audit, the MCO will provide a written summary to the Director of their audit findings. If any deficiencies were noted by the MCO, the Director is responsible for responding to the MCO with a written corrective action plan. Copies of audit report and correspondence are maintained in the OMSS.

### **Reports and/or Rosters**

1. Managed care organizations should direct any requests for reports, provider lists, HEDIS data, or rosters to the Managed Care Division of UNC Physicians and Associates.
2. UNCP&A Managed Care Division is responsible for distribution of reports of adds/deletes/changes to the managed care organizations.
3. In order to ensure that practitioner data is consistent for directories, listings, reports, etc., UNC Hospitals utilize a credentialing software program (ECHO). The database is accessible and maintained by both the Medical Staff Services and the Managed Care Offices.
2. Requests received from MCO’s for verification of hospital affiliation/privileges may be completed by the OMSS or referred to the NAMSS PASS on line repository.

### **NCQA Accreditation Survey – Request for Files**

1. MCO’s undergoing NCQA Accreditation Surveys may contact the OMSS for copies of a practitioner credentials file as part of the delegated credentialing agreement/contract with UNC Hospitals/UNCP&A.
2. The MCO will send the OMSS a list of files needed for their survey with as much notice as possible.
3. The OMSS will make a “mirror” copy of the practitioner(s) credentials file.
4. The OMSS will send the files to the MCO by overnight mail or via secure email.
5. Following the NCQA Accreditation Survey, the MCO agrees to destroy the file copies.

### **Site Visits/Medical Record Reviews**

UNC Hospitals is accredited by The Joint Commission, which is an acceptable accrediting body under NCQA CR9 – Practitioner Office Site Quality. Therefore, any MCO not willing to accept The Joint Commission accreditation will then be responsible for performing their own site visits and/or medical record reviews. The OMSS can provide the MCO with the name of the individuals to contact for arranging these visits. Following the reviews, the MCO should submit a written report to the OMSS for inclusion in the “site reviews” notebook for review by the Credentials Committee as part of the initial credentialing and recredentialing decision.

UNC Physicians & Associates Managed Care Division shall notify on a monthly basis all MCO health plans of any practitioners that relocate or open a new site location. This is necessary in order for the MCO to do a new site visit and/or medical record review, when indicated.

Any deficiency identified through the medical record review and/or the site survey shall be directed by the Credentials Committee to the Ambulatory Care Operations Committee for corrective action. The Ambulatory Care Operations Committee shall submit to the Credentials Committee a corrective plan within 30 days, and subsequent 6 month status reports on improvement until the deficiency is deemed fully corrected by the Credentials Committee.

### **HIPAA**

UNC Hospitals is committed to ensuring the privacy and security of Protected Health Information (PHI). While PHI must be available to health care professionals in the process of ensuring proper care and performing related job duties, the UNC HCS workforce and OMSS shall avoid accessing, using, or disclosing more PHI than is required to perform his/her relevant job duties or to meet the purpose for which the disclosure is made. OMSS will abide by UNC Health Care System's Privacy/Security Policies.

### **Nondiscriminatory Credentialing & Recredentialing**

UNC Hospitals does not make any credentialing or recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures (i.e. abortions) or patients (i.e. Medicaid) in which the practitioner specializes. *(Please note that practitioners are not employees of UNC Hospitals.)* As part of the initial credentialing/recredentialing application process, each practitioner is required to complete online training which includes "UNC Health Care System's Code of Conduct" which includes the following:

- Will provide high quality health care services without regard to race, color, sex, religion, national origin, age, sexual orientation, or disabilities;
- Will foster a positive work environment that discourages all forms of discrimination;
- Will recruit, hire, train and promote qualified persons in all job classifications without regard to race, color, sex, religion, national origin, age, sexual orientation, disability, and political affiliation or influence;
- Will report any suspected violations.

Upon completion of their online training, the practitioner is then required to sign/date and submit the "certification" page, which becomes part of their permanent credentials file.


In addition, Credentials Committee members are held to the same nondiscriminatory requirements noted above in making credentialing decisions and must sign the UNCHCS Code of Conduct and Confidentiality form, which becomes a part of their own credentials file.

Monitoring of nondiscriminatory credentialing and recredentialing is performed monthly by Director or Designee observation of the monthly Credentials meeting and review of meeting minutes.

### **Reporting to Authorities**

All reporting of adverse actions, malpractice, patient complaints, etc. are handled by UNCH Legal Services.

## Office of Medical Staff Services Manual

	Policy Name	<b>National Practitioner Data Bank</b>
	Policy Number	<b>OMSS 0046</b>
	Date this Version Effective	<b>January 2018</b>
	Responsible for Content	<b>Office of Medical Staff Services</b>

### POLICY

The Office of Medical Staff Services will query the National Practitioner Data Bank (NPDB) for all health care practitioners:

1. when applying for initial medical staff appointment and clinical privileges (*credentialing*);
2. when applying for reappointment and renewal of clinical privileges, (*recredentialing*); or
3. when requesting an upgrade, additional, or temporary clinical privileges; and
4. for continuous monitoring of licensure actions by the licensing boards and malpractice claim settlements.

The intent of the NPDB is to improve the quality of health care by encouraging State licensing boards, hospitals and other health care entities, and professional societies to identify and discipline those who engage in unprofessional behavior; and to restrict the ability of incompetent physicians, dentists, and other health care practitioners to move from State to State without disclosure or discovery of previous medical malpractice payment and adverse action history. Adverse actions can involve licensure, clinical privileges, professional society membership, and exclusions from Medicare and Medicaid.

**NOTE: UNC Hospitals' Legal Office is responsible for reporting "Medical Malpractice Payments" or "Adverse Actions" to the NPDB and the State Board of Medical Examiners.** OMSS will coordinate with UNCH's Legal Department to assure that any final action "adversely affecting" (as that term is defined at section 431(1) of the Health Care Quality Improvement Act) a health care practitioner's privileges is reported to the National Practitioner's Data Bank and the appropriate state agency, consistent with all relevant state and federal laws, upon the exhaustion of UNCH's hearing and appellate review process, as outlined in the Bylaws of the Medical Staff of UNC Hospitals.


### PROCEDURE

The **Credentialing Specialists** are responsible for the following with regard to obtaining information from the NPDB:

1. Views NPDB report as part of the initial appointment, reappointment, and anytime a modification in or temporary privileges are requested.
2. Notes receipt and any disciplinary or malpractice information in the workflow.
3. Investigates any disciplinary or malpractice information noted on the query responses. Forwards to the Department Chair for review, as appropriate.
4. Files the query responses and any additional documentation obtained as a result of an investigation and places it in the applicant's file for review as part of the appointment, reappointment, or other privileges review process.
5. Notifies the appropriate manager for review and resolution when a report is received via NPDB Continuous Query.



## Office of Medical Staff Services Manual

	Policy Name	<b>Office of the Inspector General (OIG) Medicare/Medicaid Sanctions Review, Review of Opt-Out Report, and System for Award Management (SAM)</b>
	Policy Number	<b>OMSS 0047</b>
	Date this Version Effective	<b>January 2018</b>
	Responsible for Content	<b>Office of Medical Staff Services</b>

### POLICY

An OIG exclusion has national scope and is important to many institutional health care providers because the Congress of the United States established a Civil Monetary Penalty for institutions that knowingly hire excluded parties. Accordingly, the OIG maintains the List of Excluded Individuals/Entities (LEIE), a database which provides information to the public, health care providers, patients and others relating to parties excluded from participation in the Medicare, Medicaid and all Federal health care programs. (\*See also P&P: Federation of State Medical Boards”) Bases for exclusion include convictions for program-related fraud and patient abuse, licensing board actions and default on Health Education Assistance Loans.

The Centralized Credentialing Office (CCO) queries the Office of the Inspector General (OIG) for Medicare/Medicaid sanctions at the time of initial appointment, reappointment for all health care practitioners. The OMSS monitors practitioner sanctions and complaints between reappointment cycles and takes appropriate action if occurrences of poor quality or sanctions are identified.


### PROCEDURE

The **Credentialing Specialists** are responsible for the following:

1. Queries the SAM, OIG online and Report of Providers Opted Out of Medicare at the time of initial appointment, reappointment, and anytime a modification in or temporary privileges are requested.
2. Views query responses received from SAM and OIG for all applicants, initials, and notes receipt on file workflow. Responses are reviewed for any sanctions and investigated as necessary. For query of Opt-Out Report, indicates on file workflow review/date/status, as appropriate.
3. Files the query responses and any additional documentation obtained as a result of an investigation and places it in the applicant's file for review as part of the appointment or reappointment process.
4. On a monthly basis, queries the HHS Office of Inspector General's online "List of Excluded Individuals/Entities" database and SAM. On a quarterly basis, queries the Medicare Opted Out list. Any UNC Hospital practitioner whose name appears on either report is given to the Director of Medical Staff Services for review/disposition. This information is reported to the Credentials Committee on a monthly basis and noted in the meeting minutes. Documentation of monitoring is maintained.

*NOTE: The Online Searchable Database enables users to enter the name of an individual or business and determine whether an exclusion is currently in effect. If a match is made on an individual, the database can verify with an individual's Social Security Number (SSN) that the match is unique. Employer Identification Numbers (EIN) (also known as Tax Identification Numbers (TIN)) are being included for recently excluded entities.*

## Office of Medical Staff Services Manual

	Policy Name	<b>Performance Monitoring</b>
	Policy Number	<b>OMSS 0048</b>
	Date this Version Effective	<b>January 2018</b>
	Responsible for Content	<b>Office of Medical Staff Services</b>

### POLICY

Practitioners at UNC Hospitals undergo extensive performance monitoring (on an ongoing basis and at reappointment) including but not limited to: performance, sanctions, licensure, adverse events, and practitioner specific complaints. Whenever the activities or professional conduct of any practitioner with delineated clinical privileges are considered to be detrimental to patient care, to be lower than the standards or aims of the Medical Staff or to be disruptive to the operations of the Hospital, *corrective action* against such practitioner may be requested by an Officer of the Medical Staff, the Chair of any clinical department, the Chair of any standing committee of the Medical Staff, the President, or the Board of Directors. Also, the President, the Chief of Staff, the Chair of the department in which the practitioner has clinical privileges, or their appointed designees, has the authority, whenever immediate action must be taken in the best interest of patient care, to *summarily suspend*, for cause, all or any portion of the clinical privileges of a practitioner with delineated clinical privileges. Such suspension shall become effective immediately upon imposition by individuals so empowered. A practitioner is entitled to a hearing before a committee of the Medical Staff when he/she receives such notice. Pending the final outcome of such actions, the Legal Office is responsible for notifying the appropriate authorities, as applicable.

**(\*See “Policy on Appointment and Corrective Action” for details of “Corrective Action” or “Summary Suspension” and “Hearing & Appellate Review Procedure”.)**

At reappointment the department Chair’s recommendation concerning the reappointment of a practitioner and the nature and scope of the clinical privileges to be granted upon reappointment is based upon such member’s professional performance; judgment and clinical competence, including, but not limited to, conclusions drawn from OPPE, quality improvement activities, ethics and conduct; attendance and participation in staff affairs; relevant training and/or experience; compliance with the *Bylaws of the Medical Staff* and the *Rules & Regulations of the Medical Staff*; cooperation with Hospital personnel; use of the Hospital’s facilities for patients; relations with other practitioners and ability to work with others; participation in appropriate continuing education; physical and mental capabilities; continuing status on the faculty of the School of Medicine or Dentistry (if applicable); contributions towards the Hospital’s objectives of patient care, education and research, if applicable; and general attitude towards patients, the Hospital, and the public.

### PROCEDURE

The Office of Medical Staff Services is responsible for querying and obtaining practitioner specific performance data from the monitoring committees as part of the reappointment process. The Medical Staff monitoring Committees input their data into the “Practitioner Database” on an ongoing basis. Individual practitioner profiles are generated from the database for review by the Department Chair’s as part of the reappointment decision-making process. Practitioner performance reports, including member complaints, that OMSS receives from the MCO’s the Hospital contracts with, are filed in the individual’s credentials file and considered as part of the reappointment process.

#### **Reappointment:**


1. The **Credentialing Specialists** (CS) are responsible for:

- A. monitoring on a monthly basis the appointment/privileges' expiration dates for all Medical Staff, Independent Allied Health Practitioners, and Dependent Allied Health Practitioners whose appointments will expire in 180 days;
  - B. querying Risk Management Director to ascertain if any claims history or patient complaint/adverse event data has been identified on any of the practitioners since their last appointment;
  - C. querying the peer review coordinators for peer review data;
  - E. monitoring return of this request from the Risk Management Director by the specified deadline; following-up as necessary
  - F. prepare cover letters to each Department Chair who has practitioners on the list, attach the practitioner evaluation forms, along with any supporting documentation;
  - H. distributes to the Department Chairs, marked as "confidential";
  - I. monitor the return of these forms by the requested deadline, following-up as necessary.
  - J. review evaluations returned by Department Chair, assures form has been completed/signed by Department Chair, and that Department Chair has indicated that he recommends or requests a change in appointment/privileges for individual;
  - K. files in the applicant's credentials file pending presentation at the next Credentials Committee meeting.
2. The **Medical Staff Services** reviews all outlier documentation while reviewing the reappointment applications in preparation for the Credentials Committee meeting and prepares a summary of the data to be used by the Credentials Committee Chair at the meeting. The summary is filed with the meeting minutes.

**Ongoing Monitoring:**


1. The **OMSS** performs ongoing monitoring for:
  - A. Medicare/Medicaid sanctions and reinstatements by reviewing the monthly lists available from the OIG, as well as the opt-out report;
  - B. Licensure sanctions by reviewing the disciplinary reports as they are received or posted by the various licensing boards;
  - C. Complaints/Adverse events are handled by the Patient Relations Department on an ongoing basis; reported to Risk Management and OMSS, as necessary;
  - D. The evidence of performance requiring a focused evaluation (FPPE) should be communicated with OMSS in order to continuously monitor the plan for improvement.
  - E. Implements actions, as necessary, based on the "Bylaws of the Medical Staff" and "Policy on Appointment and Corrective Action".

**Administrative Manual**

	Policy Name	<b>Medical Staff and Hospital Peer Review Processes</b>
	Policy Number	<b>ADMIN 0143</b>
	Date this Version Effective	<b>February 2018</b>
	Responsible for Content	<b>Medical Staff Executive Committee</b>

**See Attached – ADMIN 0143**

## Office of Medical Staff Services Manual

	Policy Name	<b>Practitioner Rights</b>
	Policy Number	<b>OMSS 0050</b>
	Date this Version Effective	<b>January 2018</b>
	Responsible for Content	<b>Office of Medical Staff Services</b>

### POLICY

All practitioners are afforded the following rights with regard to their application and the credentialing process:

1. the right to review information submitted to support their credentialing
2. the right to correct erroneous information;
3. the right to be notified about any information obtained during the organization's credentialing process that varies substantially from the information provided to the organization by the practitioner;
4. the right, upon request, to be informed of the status of their credentialing or recredentialing application;
5. right to be notified of the credentialing/recredentialing decision within 60 calendars days of the Credentials Committee decision;
6. right to a formal appeal process should action be taken against a practitioner for quality reasons;
7. notification of these rights.

All practitioners have the right to review information obtained by the Office of Medical Staff Services (OMSS) as part of the credentialing process, with the exception of references, recommendations, evaluations, or other information that is peer review protected. If credentialing information obtained by the OMSS from other sources varies substantially from that provided by the applicant, the applicant will be notified expeditiously and requested to provide a written explanation or documentation within 2 weeks to the OMSS. The applicant also has the right to correct erroneous information submitted by another party (i.e. incorrect or incomplete information provided to OMSS by the AMA profile) prior to their application being presented to the Credentials Committee.

All applications for appointment and/or clinical privileges shall contain a statement which notifies applicants of their right to review information obtained by the OMSS in order to evaluate their credentialing application, their right to correct erroneous information submitted to the OMSS by another party should it vary substantially from what the applicant originally provided, as well as instructions on how to request review of their credentials file.

### PROCEDURE

#### **Review of Credentials File by Practitioner:**

1. All practitioners are notified via their application that they have the right to review their credentials file and the process for doing so.
2. 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 Director of Medical Staff Services or a Credentialing Specialist. Requests for file review must be received in OMSS at least one working day in advance.

3. Prior to the meeting, the Director/designee or a Credentialing Specialist shall remove any documentation that was not directly provided by the practitioner or confidential/peer-review protected information (i.e. references, evaluations, outlier data, etc.). Requests by the practitioner to view any of the confidential information must first be approved by the Hospital Attorney. The practitioner may only be provided with copies of documentation that he/she originally provided (i.e. application, clinical privileges request form, DEA certificate, license, etc.) or other non-confidential documents submitted by outside sources. Confidential documentation obtained as part of the credentialing/recredentialing process may not be copied.
4. The practitioner may not view his file without the Director/designee or a Credentialing Specialist being present.

**Practitioner Notification of Erroneous Information and Right to Correct:**

1. All practitioners have the right to correct erroneous information submitted by an outside source (i.e. malpractice claims history, suspension or termination of hospital privileges, actions by state licensing boards, AMA, specialty boards, etc.) as part of the credentialing/recredentialing process.
2. If the OMSS obtains information from other sources that differs substantially from that provided by the practitioner, the OMSS will promptly contact the practitioner in writing with details of the discrepancy.
3. The practitioner will be given the opportunity to correct any factual discrepancies by: (a) providing a written explanation of why the information differs, and/or (b) providing documentation that supports their explanation (i.e. if the AMA profile indicates an individual is not board certified, but the practitioner can provide the original certificate from his/her specialty board).
4. The written explanation and/or documentation should be provided to the attention of the Director of Medical Staff Services within two (2) weeks of notification.
5. The practitioner is responsible for correcting or clarifying any discrepancies prior to his/her application being forwarded to the Credentials Committee for review. The practitioner is also responsible for contacting the outside source to correct or clarify information they provided to the OMSS.
6. Any written explanation and/or documentation provided by the applicant for the purpose of correcting or clarifying information originally provided by him/her will be placed in the credentials file, along with the original information obtained. Documentation of measures taken by both the OMSS and the practitioner will be on the file checklist.

**Practitioner Notification of Application Status and Decision:**


1. All practitioners have the right, upon request, to be informed of the status of their credentialing or recredentialing application. The Credentialing Specialists maintain a current status report on all applications in process and can readily notify an applicant and/or their Departmental Credentialing Coordinator of the status of their application. Often applicants assist the OMSS when difficulties arise in obtaining a reply from an outside reference or institution, but contacting them an explaining that their credentialing/recredentialing is being held up or jeopardized due to their failure to respond to OMSS' requests.
2. Applicants are notified in writing within 15 days after receipt of an incomplete application of all missing or incomplete information or supporting documents. An incomplete application checklist is completed by the Credentialing Specialist prior to returning the application packet back to the applicant. The checklist indicates what information is missing or incomplete, as well as the name/address/phone/fax number of the Credentialing Specialist to whom they should return the application.

3. All practitioners have the right to be notified of their credentialing/recredentialing decision within 60 calendar days of the Credentials Committee decision. OMSS sends out letters notifying applicants of such decisions immediately following the Credentials Committee, as well as the Board of Directors meetings.

**Practitioner Appeal Rights:**

1. All practitioners that undergo a “corrective action” or a “summary suspension” due to disciplinary actions or for quality reasons, are entitled to a hearing before a committee of the Medical Staff. (*\*See UNC Hospitals’ “Bylaws of the Medical Staff” for specific details*).

## Office of Medical Staff Services Manual

	Policy Name	<b>Privilege Request Forms</b>
	Policy Number	<b>OMSS 0051</b>
	Date this Version Effective	<b>January 2018</b>
	Responsible for Content	<b>Office of Medical Staff Services</b>

### POLICY

Each clinical department has clinical privileges request form(s) for their Medical Staff. Some departments also have individual forms for each division. There are also individual forms for requesting special privileges, such as Acupuncture, Cyberknife, Laser, Robotic Surgery, Sedation, and Trauma Team privileges.

Independent Allied Health Professionals and Dependent Allied Health Professionals may use a privileges request form if one has been developed by their department. Otherwise, the Allied Health Professionals request practice privileges by submitting a scope of practice, job description, list, etc. which details what their responsibilities will be. This must be signed/dated by the applicant, their physician supervisor, as well as their Department Chair.

An updated privilege request form must be submitted at the time of initial appointment, reappointment, as well as anytime an applicant is seeking additional privileges. Also, should an applicant or Department Chair request a reduction in privileges, an updated form must be completed.

Departments are responsible for the ongoing review of privilege forms for needed changes, as technology and medical advancements are made. Department Chairs (Division Chiefs, if applicable) are responsible for reviewing/approving privileges being requested by a practitioner and for assuring the applicant has met the criteria (i.e. education, training, experience, certification) for the privileges being requested.

**All privilege forms must be submitted to the Credentials Committee for review and approval prior to use and implementation. Departments are responsible for submitting any requests for revised forms to the Director in the Office of Medical Staff Services for inclusion on the next Credentials Committee agenda.**

### PROCEDURE


The OMSS maintains current copies of all departmental clinical privilege request forms, as well as special privilege forms, and distributes forms with application packets at the time of appointment and reappointment.

The OMSS assists the departments with recommended criteria, format, etc. for privilege forms by subscribing to the "Clinical Privilege White Papers" as well as other resources and provides the departments with information.

The OMSS places revised forms on the agenda for Credentials Committee review. After review by the Credentials Committee, forms are then forwarded to the Executive Committee for review/approval.



## Office of Medical Staff Services Manual

	Policy Name	<b>Professional Liability Insurance Coverage &amp; Claims History</b>
	Policy Number	<b>OMSS 0052</b>
	Date this Version Effective	<b>January 2018</b>
	Responsible for Content	<b>Office of Medical Staff Services</b>

### POLICY

The University of North Carolina School of Medicine and UNC Hospitals has a “Liability Insurance Trust Fund” – which is a program of professional liability self-insurance with respect to covered parties. Covered parties include, but are not limited to the following, under the Trust Fund: any Active physician employed full-time by UNC School of Medicine, any health care practitioner who is an employee of a covered entity and who renders health care to patients by direct ministration or by indirect ministration upon orders of one who renders health care to patients by direct ministration (i.e. nurse practitioners, physician assistants). The coverage, limits of liability, exclusions from coverage, and the duties and responsibilities of both the insureds and the Trust Fund are more clearly defined in the current “*Memorandum of Coverage*” which is distributed by the Legal Department at UNC Hospitals.

Practitioners that are not covered by the UNC Liability Insurance Trust Fund are responsible for providing evidence of current professional liability insurance coverage to the Office of Medical Staff Services at the time of credentialing, recredentialing and renewal. In addition, at initial credentialing, they must provide the names of past insurance carriers in order for the OMSS to investigate their claims history. The applicant will provide claims history from their insurance carriers for the preceding five (5) years. Any claims history identified is investigated by the OMSS and appropriate Department Chair.

All application packets contain a “Liability Insurance Confirmation Form” which should be completed by the Departmental Credentialing Coordinator, indicating whether an applicant will be covered by the Trust Fund or an Outside Carrier. In addition, the application packets contains a memo to the part-time practitioners regarding professional liability insurance requirements and a claims history questionnaire form, which the applicant must send to their insurance carrier along with a cover letter authorizing release of this information to OMSS.

The Office of Legal Services and Risk Management is responsible for reporting malpractice history to the NC Medical Board and NPDB.

### PROCEDURE

The **Credentialing Specialists** are responsible for the following with regard to professional liability claims history on practitioners:

#### Initial Credentialing:

1. Reviews the credentialing application to determine whether or not an applicant:
  - a. will be covered by the Trust Fund; or
  - b. will be covered by an outside insurance carrier.

2. If covered by an outside insurance carrier, reviews the claims history form received from the insurance carrier, as well as the credentialing application received from the applicant, for any claims history or exclusions. Verifying that the amounts of coverage provided for on the certificate of insurance meet the Hospital's requirements and verifying that the dates of the policy are current.
3. If the insurance carrier does not provide adequate information for investigation, then the physician is contacted for additional details:
  - a. Name of Plaintiff
  - b. Date of Claim
  - c. Location of Claim
  - d. Brief Description of Claim
  - e. Status of Claim
  - f. Name/Address/Phone of Attorney
4. In the process of reviewing applications for credentialing, the malpractice history of the applicant as described on his/her application is also reviewed. If the applicant lists any suit in which he/she has been named as a defendant, the applicant contacts the insurance carrier for additional information and status/outcome of the claim as requested on the application. If the situation described by the applicant occurred at UNC Hospitals (i.e. during residency training), the Legal Office is contacted and is able to provide the OMSS with written details of the case.
5. Initial credentialing applications are reviewed to ascertain if applicant holds or has held insurance with insurance carriers other than their current carrier. If so, the applicant is required to contact the insurance carriers to provide claims history for the preceding five (5) years. This would also include contacting the Office of Risk Management at all institutions where the applicant trained (if preceding 5 years includes training years), and/or all subsequent private carriers for the prior five year period.
6. Once then OMSS has investigated fully the claims history, a letter is sent to the appropriate Department Chair notifying him/her of the investigation and a copy of all documentation is provided to them for their review.
7. Once the Department Chair reviews the information, he/she must provide the OMSS with a letter indicating that he/she has reviewed the documentation, investigated and discussed with the applicant, and indicate whether or not it should affect the applicant's request for credentialing and granting of clinical privileges.
8. The application is held pending receipt of the response from the Department Chair. All information and correspondence generated as a result of the investigation of claims history is filed in the applicant's file and is "Confidential".
9. Prior to the Credentials Committee meeting, all claims history will be reviewed by the Director of Medical Staff Services and, where appropriate, a brief summary is prepared for use by the Chair of the Credentials
10. Prior to the Credentials Committee meeting, the Chair of the Committee reviews all applications with legal investigations, along with the summary of cases prepared by the Director of Medical Staff Services. All files and supporting documentation are pulled for review and discussion at the meeting with Committee members.

**Recredentialing:**


1. Reviews the recredentialing application to determine whether or not an applicant:
  - a. is still covered by the Trust Fund; or
  - b. is covered by an outside insurance carrier.
2. Reviews the recredentialing application received from the applicant, for any claims history or exclusions not previously investigated as part of the credentialing or recredentialing process. Verifies that the amounts of coverage provided for on the certificate of insurance meet the Hospital's requirements and verifying that the dates of the policy are current.
3. If the recredentialing application indicates any claims history that has not already been previously investigated as part of the credentialing/recredentialing process, then the CS reviews the claim(s). If the applicant does not provide adequate information for investigation, then the applicant is contacted for additional details:
  - a. Name of Plaintiff
  - b. Date of Claim
  - c. Location of Claim
  - d. Brief Description of Claim
  - e. Status of Claim
  - f. Name/Address/Phone of Attorney
4. In the process of reviewing applications for recredentialing, if the applicant lists any suit in which he/she has been named as a defendant and the situation occurred at UNC Hospitals, the details should have been reported to OMSS by Risk Management as part of the "outlier" process. If not, then the Legal Office is contacted for written details.
5. Once the OMSS has investigated fully the claims history, a letter is sent to the appropriate Department Chair notifying him/her of the investigation and a copy of all documentation is provided to them for their review.
6. Once the Department Chair reviews the information, he/she must provide the OMSS with a letter indicating that he/she has reviewed the documentation, investigated and discussed with the applicant, and indicate whether or not it should effect the applicant's request for credentialing and granting of clinical privileges.
7. The application is held pending receipt of the response from the Department Chair. All information and correspondence generated as a result of the investigation of claims history is filed in the applicant's file and is "Confidential".
8. Prior to the Credentials Committee meeting, all claims history will be reviewed by the Director of Medical Staff Services and, where appropriate, a brief summary prepared for use by the Chair of the Credentials Committee.
9. Prior to the Credentials Committee meeting, the Chair of the Committee reviews all applications with legal investigations, along with the summary of cases prepared by the Director of Medical Staff Services. All files and supporting documentation are pulled for his review and then he discusses these at the meeting with Committee members.

Individuals who are covered by outside insurance carriers are responsible for providing evidence of current professional liability coverage on an ongoing basis. Copies of their "Certificate of

Insurance” should be forwarded to OMSS as the insurance information is maintained in the OMSS’ credentialing software program. OMSS staff shall notify individuals whose insurance is due to expire, requesting that they submit a current certificate. Practitioners with expired professional liability coverage shall be subject to automatic administrative action per Article VI, Section 3 b. of the Bylaws until evidence of current insurance is received.

10. The UNC Liability Insurance Trust Fund distributes a copy of the updated “Memorandum of Coverage” to all individuals covered by the self-insured plan. The liability coverage period is from July 1<sup>st</sup> to June 30<sup>th</sup> each year.

## Office of Medical Staff Services Manual

	Policy Name	<b>Provider Coding &amp; Compliance Training</b>
	Policy Number	<b>OMSS 0053</b>
	Date this Version Effective	<b>January 2018</b>
	Responsible for Content	<b>Office of Medical Staff Services</b>

### **POLICY**

UNC Hospitals and UNC School of Medicine have collaborated to develop an integrated curriculum to cover essential information needed for billing compliance and for certain clinical operations. The curriculum includes and enhances the mandatory coding and documentation education called for in the UNCP&A Clinical Faculty Compliance Plan. Failure to complete this mandatory training can result in suspension and/or termination of Hospital appointment and/or clinical privileges. **NOTE: Some types of training are not applicable for different provider types. Refer to the compliance training website for more information.**

### **PROCEDURE**


#### **Initial Appointment:**

1. OMSS includes a “Initial Appointment Online Training Requirements” checklist as part of an initial appointment application packet sent to the department/applicant.
2. The applicant must follow the instructions on the checklist, sign/date the checklist, and return it to their Departmental Credentialing Coordinator, along with their initial appointment application packet.
3. The Departmental Credentialing Coordinator is responsible for assuring the applicant has completed the checklist, and is then responsible for forwarding the checklist and supporting documentation to the UNC Compliance Office.
4. At the time an applicant is granted an appointment and assigned their UNC Hospitals code number, an email is sent to the Compliance Office. The Compliance Office is responsible for coordinating all aspects of the provider education, as well as tracking compliance with this requirement.

#### **Reappointment:**

1. OMSS includes a “Compliance Training Instructions – Reappointment” (certification form) as part of the reappointment application packet sent to the department/applicant.
2. The applicant must follow the instructions on the checklist, sign/date the checklist (certification form), and return it to their Departmental Credentialing Coordinator, along with their reappointment application packet. Reappointment applications cannot be processed without completion of this required training.
3. The Departmental Credentialing Coordinator is responsible for assuring the applicant has completed the checklist (certification form), for grading the applicant’s training “post-tests”, and for maintaining the tests and supporting documentation in their departmental file.
4. The Departmental Credentialing Coordinator must return the “Compliance Training Instructions – Reappointment” (certification form) to OMSS as part of the applicant’s reappointment application packet.

## Office of Medical Staff Services Manual

	Policy Name	<b>Accreditation and Regulatory Agencies</b>
	Policy Number	<b>OMSS 0054</b>
	Date this Version Effective	<b>January 2018</b>
	Responsible for Content	<b>Office of Medical Staff Services</b>

### POLICY

The Office of Medical Staff Services (OMSS) is responsible for UNC Hospitals credentialing program. The Director of Medical Staff Services is responsible for keeping up-to-date on credentialing standards as mandated by Joint Commission (JC), National Committee for Quality Assurance (NCQA), North Carolina Department of Insurance (NC-DOI), Centers for Medicare and Medicaid Services (CMS), Utilization Review Accreditation Commission (URAC), as well as North Carolina licensure laws, UNC Hospitals' Bylaws of the Medical Staff and various other regulations. While UNC Hospitals is accredited by Joint Commission, this office must also maintain compliance with the credentialing standards as mandated by the agencies that grant accreditation to the managed care organizations. Most of the managed care organizations that have contracts with UNC Hospitals have opted to delegate their credentialing responsibilities to UNC Hospitals' Office of Medical Staff Services. These managed care organizations perform annual on-site audits of credentials files, policies and procedures to assure compliance with NCQA, URAC, and NC-DOI standards. Failure to comply with any of the accreditation or regulatory standards may jeopardize accreditation, licensure of the hospital, and managed care contracts.

### PROCEDURE

In order to keep up-to-date and compliant with the above credentialing standards, on an annual basis the Director of Medical Staff Services is responsible for:


- obtaining updated accreditation manuals or regulations from all of the above agencies;
- reviewing the updated standards against current OMSS credentialing policies and procedures;
- revising the OMSS credentialing policies and procedures by adding, revising, or deleting credentialing requirements;
- obtaining Credentials Committee review/approval of the OMSS policies/procedures on an annual basis;
- providing current OMSS policies/procedures to all managed care organizations that delegate credentialing to UNC Hospitals.

The Director participates in the triennial survey by **The Joint Commission** of UNC Hospitals. The physician surveyor requests randomly selected credentials files and reviews for compliance against the credentialing standards. Policies/Procedures, Credentials Committee meeting minutes, and other documentation may also be reviewed for compliance.

The Director or designee participates in the annual audits by the various managed care organizations that have delegated credentialing agreements as part of their contracts with UNC Hospitals. The auditors request randomly selected credentials files for providers that are part of their panel. Policies/Procedures, Credentials Committee meeting minutes, and other documentation may also be reviewed for compliance with **NCQA, NC-DOI, and URAC** credentialing standards.

The Director or designee assists the managed care organizations when they undergo NCQA accreditation surveys by providing them with copies of the credentials file(s) that are randomly selected by NCQA.

## Office of Medical Staff Services Manual

	Policy Name	<b>Termination – Medical Staff</b>
	Policy Number	<b>OMSS 0055</b>
	Date this Version Effective	<b>January 2018</b>
	Responsible for Content	<b>Office of Medical Staff Services</b>

### POLICY

Appointment to the Medical Staff may be terminated prior to the expiration of the period of appointment or reappointment only by one of the following means:

1. Voluntary resignation by a member of the Medical Staff, submitted in writing to the Office of Medical Staff Services.
2. Automatic administrative action evidenced by the failure of the member of the Medical Staff to continuously meet the qualifications, standards and requirements set forth in the *Bylaws of the Medical Staff*, including by way of example and not limitation:
  - failure to maintain a faculty appointment required for Active Staff; and
  - failure to obtain or maintain licensure, board certification status, or medical malpractice insurance required for the staff category.

Termination of appointment by automatic administrative action is final and the individual shall not be entitled to the Hearing & Appellate Review Procedures outlined in the *Bylaws of the Medical Staff*.

3. Corrective action in accordance with the *Bylaws of the Medical Staff*.

As outlined in the *Bylaws of the Medical Staff*, the President, the Chief Medical Officer, the Chair of the department in which the practitioner has clinical privileges, or their appointed designees, has the authority, whenever immediate action must be taken in the best interest of patient care, to summarily suspend, for cause, all or any portion of the clinical privileges of a practitioner with delineated clinical privileges. Such suspension shall become effective immediately upon imposition by individuals so empowered.

*\* In the case where a physician's appointment and/or clinical privileges are terminated due to unfavorable reasons, the Legal Department is responsible for notifying the NCBME, NCDB, and NPDB.*

## PROCEDURE


The **Departmental Credentialing Coordinator** is responsible for notifying the OMSS Credentialing Specialist of all practitioner terminations. They should follow the instructions for completing the “Practitioner Termination Form”, attaching supporting documentation, obtaining signatures, and then submitting it to OMSS.

Upon receipt in OMSS, the **Credentialing Specialist** is responsible for the following with regard to processing termination of a practitioner’s hospital appointment and/or clinical privileges:

1. Pulls the individual’s credentials file (only if in process by CCO or OMSS).
2. Updates the Echo credentialing system with termination date and changes their status on the appropriate screens/fields.
3. Sends email notification of practitioner termination and/or suspension to the SER Table, which includes authorities in the Hospital and University, (i.e. Operating Room, Medical Information Management, ISD Security, Administration, Pharmacy, Radiology, Labs, UNC Physicians & Associates, Managed Care - who in turn notify the various MCO’s as part of the contract agreements).
4. *Scan and map termination packet to Echo.*



## Office of Medical Staff Services Manual

	Policy Name	<b>Termination: Allied Health Professionals</b>
	Policy Number	<b>OMSS 0056</b>
	Date this Version Effective	<b>January 2018</b>
	Responsible for Content	<b>Office of Medical Staff Services</b>

### POLICY

Allied Health Professionals are not members of the Medical Staff and accordingly shall have no recourse to the procedural rights specified in the *Bylaws of the Medical Staff*. An Allied Health Professional shall promptly report to the Office of Medical Staff Services any significant change in information previously provided as part of prior applications for appointment or reappointment. This includes, but is not limited to:

- changes in professional licensure/certification, DEA, malpractice coverage;
  - involvement in any malpractice activity; or
  - disciplinary action by any licensing or certification board or healthcare facility.
1. In the event that an Allied Health Professional's certification or licensure is adversely affected in any manner, his/her practice privileges shall be immediately and automatically restricted, suspended, or terminated accordingly.
  2. In the event that an Allied Health Professional's professional liability insurance is terminated for any reason, his/her practice privileges shall be immediately and automatically terminated.
  3. The practice privileges of a Dependent Allied Health Professional shall be automatically suspended or terminated if the clinical privileges of all his/her sponsoring or collaborative Active Medical Staff members are suspended or terminated for any reason.
  4. The President or Chief Medical Officer may restrict, suspend, or terminate any or all of the practice privileges of an Allied Health Professional without recourse to the procedural rights specified in the *Bylaws of the Medical Staff*.
    - a) An Independent Allied Health Professional whose practice privileges are restricted, suspended, or terminated will be notified of the action and the reasons for such action, and may request that such action be reviewed by the Medical Staff Executive Committee. At any such review meeting, the individual may be present and may participate in the review. The individual will be entitled to a written report at the conclusion of the review, but will not be entitled to any further internal review or appeal.
    - b) A Dependent Allied Health Professional whose practice privileges are restricted, suspended, or terminated will be notified of the action and the reasons for such action, and may request that such action be reviewed by the Medical Staff Executive Committee. At any such review meeting, the individual and his/her sponsoring or collaborative Active Staff member or members may be present and may participate in the review. The individual will be entitled to a written report at the conclusion of the review, but will not be entitled to any further internal review or appeal.

*\* In the case where a practitioner's appointment and/or privileges are terminated due to unfavorable reasons, the Legal Department is responsible for notifying the appropriate licensure board and NPDB.*


## PROCEDURE

The **Departmental Credentialing Coordinator** is responsible for notifying the OMSS Credentialing Specialist of all practitioner terminations. They should follow the instructions for completing the “Practitioner Termination Form”, attaching supporting documentation, obtaining signatures, and then submitting it to OMSS.

Upon receipt in OMSS, the **Credentialing Specialist** is responsible for the following with regard to processing termination of a practitioner’s hospital appointment and/or clinical privileges:

1. Pulls the individual’s credentials file (only if in process by CCO or OMSS).
2. Updates the Echo credentialing system with termination date and changes their status on the appropriate screens/fields.
3. Sends email notification of practitioner termination and/or suspension to the SER Table, which includes authorities in the Hospital and University, (i.e. Operating Room, Medical Information Management, ISD Security, Administration, Pharmacy, Radiology, Labs, UNC Physicians & Associates, Managed Care - who in turn notify the various MCO’s as part of the contract agreements).
4. *Scans and maps termination packet to Echo.*

## Office of Medical Staff Services Manual

	Policy Name	<b>Retention of Inactive Credentials Files</b>
	Policy Number	<b>OMSS 0057</b>
	Date this Version Effective	<b>January 2018</b>
	Responsible for Content	<b>Office of Medical Staff Services</b>

### POLICY


Upon receipt of a “Practitioner Termination Form” and supporting documentation (i.e. official notification for other reasons to terminate a practitioner’s appointment and/or clinical privileges), and processes the termination per the “*P&P for Termination of Staff Privileges*”. Once the termination has been processed, then the credentials file is prepared for conversion to digital format.

The OMSS maintains electronic format (Papervision & Echo) on practitioners that have terminated since 1969. Prior to 1969, clinical departments were responsible for credentialing practitioners.

### PROCEDURE

1. When a “Practitioner Termination Form” is received, the **Credentialing Specialist** processes the termination and electronically stores the documentation.

## Office of Medical Staff Services Manual

	Policy Name	<b>Verification of Past/Current Hospital Affiliation &amp; Privileges at UNCH</b>
	Policy Number	<b>OMSS 0058</b>
	Date this Version Effective	<b>January 2018</b>
	Responsible for Content	<b>Office of Medical Staff Services</b>

### POLICY


The Office of Medical Staff Services (OMSS) is responsible for verifying past/current appointments and/or clinical privileges held by practitioners at UNC Hospitals. The OMSS receives requests from hospitals, insurance companies, licensing boards, etc. from across the state and nation. Those requesting verifications are referred to NAMSS PASS, if applicable. If the practitioner is not in NAMSS PASS and a letter of good standing cannot be provided, the request must be in writing with a copy of an authorization for release of information signed by the applicant. The OMSS must have this authorization before releasing any information. OMSS will communicate with the Legal Department to prepare a letter for a practitioner that is not in good standing.

### PROCEDURE

1. The Credentialing Specialist (CS) is responsible for reviewing the request and forwarding information about NAMSS PASS.
2. If the requesting entity asks about malpractice history and the applicant is/was involved in a claim, the CS should forward the form/letter to Risk Management in the UNC Hospitals Legal Office.
3. If the requesting entity asks for an evaluation of the applicant's clinical skills and competence, then the CS should forward the form/letter to the appropriate Department Chair.
4. If the requesting entity asks for verification of internship/residency training, then the form/letter, then the CS should forward the form/letter to the Office of Graduate Medical Education.
5. If a request for verification is received and the CS is unable to find any record of the practitioner ever having had hospital appointment and/or privileges, the CS should check with the clinical department to see if any record can be found. If after further investigation no record can be found of the practitioner, then the CS should prepare a letter back to the requesting entity that no record of the individual is available.

***NOTE:** The Office of Medical Staff Services has inactive files that date back to February 1969. Prior to 1969, it was the responsibility of the clinical departments in the School of Medicine and Dentistry to credential physicians practicing at the Hospital.*

## Office of Medical Staff Services Manual

	Policy Name	<b>Abbreviated Credentialing Process at UNC Hospitals</b>
	Policy Number	<b>OMSS 0059</b>
	Date this Version Effective	<b>January 2018</b>
	Responsible for Content	<b>Office of Medical Staff Services</b>

### Policy

It is the policy of the UNC Health Care System (UNCHCS) to credential practitioners consistent with the established standards of UNCHCS as well as the requirements of accreditation and regulatory bodies. The intent of this policy is to establish an abbreviated credentialing process for practitioners that have been credentialed by a UNCHCS facility.

### Procedure

Practitioners who are currently credentialed with membership and privileges at a UNCHCS facility may apply for membership and privileges at an additional UNCHCS facility by completing the following:

- UNCHCS Uniform Application (some sections may be pre-populated or may use existing application if completed within prior 24 months with updates and new signed attestation);
- NCDOI Attestation;
- Physician Acknowledgement Statement (if applicable);
- Facility Privilege Form;
- Providing a copy of current Malpractice Insurance Coverage; and
- Facility specific documents or training.

Once the completed application and privilege form are received, the Centralized Credentialing Office (CCO) processes the application by:

- Reviewing the primary source verifications of education and training completed previously, if available, to ensure all current requirements are met or obtain required verifications;
- Obtaining a competency evaluation form from the Department Chair, Chief of Staff or VPMA/CMO of the UNCHCS facility where the applicant holds clinical privileges;
- Verifying current medical licensure;
- Verifying current DEA;
- Verifying current board certifications;
- Confirming current malpractice insurance coverage;
- Obtaining facility National Practitioner Data Bank report; and
- Verifying applicant has NO sanctions.
- Verifying ECFMG, if applicable

Once all information is received, the application is forwarded to the requesting facility and processed in accordance with the facility Medical Staff Bylaws and Credentialing Policies.

## Office of Medical Staff Services Manual



Policy Name	<b>Privileges: Central Line Insertion</b>
Policy Number	<b>OMSS 0060</b>
Date this Version Effective	<b>July 2018</b>
Responsible for Content	<b>Office of Medical Staff Services; Epidemiology</b>

### **POLICY**

Only those providers who have been authorized by the UNC Health Care System Board of Directors (upon recommendation by the Credentials Committee and Executive Committee of the Medical Staff) shall be permitted to insert central lines or supervise central line insertions. As part of the organizational goals, it is necessary to receive standardized training on UNC's best practice for central line insertion for infection prevention and patient safety.

### **PROCEDURE**

- I. The Applicant should complete, sign/date the Clinical Privileges Request Form for Central Line Insertion and submit it to their Departmental Credentialing Coordinator, along with the following:

#### **A. NEW PRIVILEGES**

1. All physicians in good standing with the North Carolina Medical Board must take the LMS module and achieve 100% correct answers
2. All Advanced Practice Providers in good standing with their respective board must take the LMS module and achieve 100% correct answers
3. Any physician or APP who desires central line insertion privileges whose prior training, competency, and experience cannot be confirmed will be recommended to undergo in-person, simulation-based training. This training is also available to any provider on an elective basis.

#### **B. RENEWAL OF PRIVILEGES**

1. A physician in good standing with the North Carolina Medical Board, or APP in good standing with their respective board.
  2. 100% correct answers on LMS module every 2 years.
- II. The Departmental Credentialing Coordinator will then have the Department Chair review the documentation, and requested privileges. Department Chair must sign all requests for central line privileges, thus indicating his/her approval.
  - III. The Departmental Credentialing Coordinator will then submit the materials to the Centralized Credentialing Office for processing. The central line insertion request will be presented to the full Credentials Committee.
  - IV. Once central line insertion privileges are granted, renewal of these privileges will be considered as part of the reappointment process.
  - V. Following review by the Credentials Committee, OMSS will notify the applicant of the Committee's decision.

## Office of Medical Staff Services Manual



Policy Name	<b>Privileges: Fluoroscopy</b>
Policy Number	<b>OMSS 0061</b>
Date this Version Effective	<b>July 2018</b>
Responsible for Content	<b>Office of Medical Staff Services; Radiation Safety Subcommittee</b>

### POLICY

Only those providers who have been authorized by the UNC Health Care System Board of Directors (upon recommendation by the Credentials Committee and Executive Committee of the Medical Staff) shall be permitted to use Fluoroscopy. It is necessary to receive training in standard operating practice.

### PROCEDURE

#### A. NEW PRIVILEGES: REQUIREMENTS

All providers who operate or supervise the operation of x-ray producing equipment must show documentation that they meet one of the following requirements for radiation safety training:

1. Board certification, or Board eligibility in Diagnostic Radiology, Interventional Radiology, Interventional Cardiology, Radiation Oncology, OR
2. Board certified in a specialty, which includes formal competency-based training consisting of didactic and supervised hands-on experience relating to the operation of radiation-producing equipment, must provide documentation OR
3. 80% correct answers on the UNC Hospitals LMS Module, Safe Use of Fluoroscopy Equipment
4. In addition to the above requirements, providers performing Fluoroscopy in GI Procedures at the Main Campus and at the Hillsborough Hospital Medical Office Building will need to complete equipment specific training.

#### B. RENEWAL OF PRIVILEGES: REQUIREMENT

1. 80% correct answers on the UNC Hospitals LMS Module, Safe Use of Fluoroscopy Equipment
- I. The Departmental Credentialing Coordinator will then have the Department Chair review the documentation, and requested privileges. Department Chair must sign all requests for Fluoroscopy privileges, thus indicating his/her approval.
  - II. The Departmental Credentialing Coordinator will then submit the materials to the Centralized Credentialing Office for processing. The Fluoroscopy request will be presented to the full Credentials Committee.
  - III. Once Fluoroscopy privileges are granted, renewal of these privileges will be considered as part of the reappointment process.
  - IV. Following review by the Credentials Committee, OMSS will notify the applicant of the Committee's decision.