The makings of an MSP

New NAMSS releases feature definitions, competencies for the profession

September was a banner month for the National Association Medical Staff Services’ (NAMSS) professional development and advocacy work. Against the backdrop of its 40th educational conference in Boston, the organization rolled out two resources intended to broaden professional awareness, pave viable career paths, and establish national standards for MSPs.

During the conference’s opening keynote presentation, NAMSS unveiled *The State of the Medical Services Profession*. The special report, based on 2014 research, spotlights the evolution of medical staff services from a clerical position to a multifaceted career, summarizes core functions and experience-based skill sets for the profession, and points to factors that will shape its trajectory in the years ahead.

Hot on the heels of this reveal, NAMSS submitted comments to the Office of Management and Budget (OMB) requesting the inclusion of a detailed occupational listing for MSPs in the 2018 Standard Occupational Classification (SOC) system and associated manual.

Federal statistical agencies and other organizations use the SOC to classify workers into occupational categories for the purpose of sharing, analyzing, and comparing meaningful workforce data. The latest version of the SOC, which took effect in 2010, features 840 detailed occupations.

NAMSS’ September comments represent the latest push in a long-running campaign to expand access and robustness of MSP statistics through formal recognition in the SOC.

“There is currently no clear estimate of how many individuals are serving as MSPs nationwide,” the NAMSS comments state. “Inclusion of the profession as a detailed occupational classification in the SOC would bridge this data gap and allow for the identification of those who are performing the essential functions and responsibilities of an MSP in various professional healthcare settings.”

NAMSS first requested publication of a detailed occupational entry for MSPs in the 2010 SOC. The OMB’s SOC policy committee denied this request on...
the grounds that the profession’s duties were sufficiently covered in the entries for human resources and compliance occupations.

When development began for the 2018 SOC, NAMSS again called for the inclusion of MSPs, this time recommending placement of the entry in the “medical and health services managers” category (11-911X) and providing a specific definition (Figure 1). The committee denied the proposal, citing potential classification and data collection issues. “Each occupation is assigned to only one category at the lowest level of classification … Medical Service Professionals could be classified in more than one existing SOC occupation based on the work performed,” the committee wrote in its response.

The OMB published its latest summary of proposed updates to the 2018 SOC in the Federal Register on July 22. The notice includes a list of 16 brand-new detailed occupations; an entry for MSPs is not among them.

Figure 1: NAMSS’ proposed SOC definition for MSPs

11-911X, Medical Services Professionals
Administer the credentialing, privileging, and onboarding processes for physicians and independent practitioners into health systems in accordance with federal regulations and national accreditation criteria. May manage practitioner medical education programs, administer medical staff governance, manage peer review, and administer payer enrollment. Excludes Human Resource Managers, Human Resource Specialists, recruiting, compensating, and supervising medical staff personnel.


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NAMSS’ September comments—which reflect input from a cross-section of the association’s board, staff, and membership—articulate the nuanced distinction between medical staff services and similarly situated professions already in the SOC. The comments also incorporate findings from The State of the Medical Services Profession report to illustrate MSPs’ hallmark competencies in credentialing, privileging, primary source verification, peer review, compliance, departmental operations, and medical staff management.

The OMB expects to finalize the SOC revision by spring 2017. If the agency moves forward without an MSP entry, the profession faces a long wait before resuming the cause; the next planned update to the SOC is not until 2028.

CRCJ reached out to NAMSS president Bonnie Enloe Gutierrez, CPMSM, CPCS, for more insight into both of NAMSS’ September releases. In the following Q&A, Gutierrez, who also serves as medical staff services director for the South Denver (Colorado) Operating Group of Centura Health, reveals what the interconnected advocacy efforts mean for the modern MSP.

Q What has inspired NAMSS’ repeated petitioning of the OMB to publish a detailed occupational listing for MSPs in the SOC Manual?

A NAMSS continues to pursue recognition of MSPs in the SOC Manual because of the unique and crucial role that MSPs play in the healthcare industry. We are the gatekeepers of patient safety, the first line of defense in ensuring providers are who they say they are and are as qualified as they say they are. We undergo rigorous certification and training for the specific duties we perform. Recognition of MSPs in the SOC Manual would serve as validation of what we already know to be true: that MSPs are distinct from other recognized occupations and are vital to ensuring safe patient care through a qualified medical staff.

Q What are the next steps in this effort?

A NAMSS is seeking a meeting to further advance the arguments made in our submitted SOC comments. We will continue to advocate for MSPs to ensure that they receive the recognition they so rightly deserve.

Q What drove development of The State of the Medical Services Profession report?

A In the course of developing education courses for our members through surveys, focus groups, and research, NAMSS realized that there was an important story to tell about the MSP profession. We realized that there was a need for a comprehensive resource on the state of the profession and the various roles and functions of the MSP throughout the healthcare industry.

Q Do these initiatives reflect any broader trends in the profession and/or in the overarching healthcare industry?

A The work of MSPs throughout the healthcare industry will continue to be affected by the move from volume-based to value-based medicine. Physicians and other practitioner payments are increasingly based on quality outcomes. The public has direct access to a wealth of information on practitioners’ performance and patient/member satisfaction. Healthcare providers will continue to have a greater interest in recruiting and retaining high-quality, rather than highly productive, practitioners.

Hungry for more advocacy ideas?

Professional recognition and advancement are keys to maintaining a productive, engaged workforce—not to mention major emphases of National Medical Staff Services Awareness Week, which was held November 6–12 this year. For insights on how MSPs are celebrating the profession and driving widespread acknowledgement, check out our complete Awareness Week coverage on the CRC site.

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Greater recognition of the MSP profession and a clearer understanding of MSPs’ roles and functions through these initiatives will help them remain at the forefront of their organizations’ efforts to provide safe, high-quality care.

Q What feedback have you received from MSPs?

A We have heard from many of our MSP members supporting the SOC comments. They know better than anyone that they play a unique role in the healthcare industry, and NAMSS is honored to speak on their behalf. Our introduction of The State of the Profession at our 2016 annual conference in Boston was met with great enthusiasm, as well. Our members clearly appreciate the value of this report, both in its ability to increase the recognition of the MSP profession and as a professional development tool.

Q How can MSPs use the new NAMSS report to facilitate their daily work, foster professional development, and/or propel career advancement?

A The new NAMSS State of the Profession Report is a versatile document that can be used by

MSPs to fit the needs of their own situation, their staff, and their management. It is an educational tool meant to build awareness of the history, role, and importance of the MSP profession. Specifically, I believe that this report clearly delineates areas of responsibility and could be used by MSPs to work with their chief medical officers and HR departments to ensure that they have accurate job descriptions in place. As we all know, job descriptions are a necessary tool in ensuring that our roles are appropriately ranked within organizations for reporting structures, titles, salaries, etc.

Q What can MSPs do to improve recognition and support of their profession within and beyond their organization?

A Being able to clearly articulate their value, core functions, and role within the constantly changing healthcare landscape will further expand the profession’s reach and importance. This is where the new State of the Profession report can be particularly useful. For example, this report is an excellent tool for recruiting the next generation of MSPs. With an appropriate degree of passion, it explains our value in the patient safety arena and should motivate young professionals to seek administrative roles in healthcare.

**Immediate uses**

The National Association Medical Staff Services’ (NAMSS) latest advocacy initiatives establish parameters for medical staff services and seek to broaden general understanding of the profession. But the road to systemic change is often long. How, if at all, can MSPs leverage the organization’s Standard Occupational Classification (SOC) comments and The State of the Medical Services Profession report in their more immediate duties, career goals, and departmental operations?

For Barbara Warstler, MBA, CPMSM, director of medical staff services and credentialing at University Hospitals (UH) in Cleveland, the resources present two major opportunities for individual and department-level use:

- Spread the word about the distinctive, complex, and skilled nature of the profession
- Standardize roles and responsibilities

**Spread the word**

A clearly defined and reflective scope of work is just as important for MSPs as for the practitioners they credential. NAMSS’ SOC comments and special report showcase the diversity and specialization in the field, upping the “street credibility” of a profession whose rapid evolution can elude general understanding, says Warstler. For example, hospital leaders who have been in healthcare for a long time may mistake medical staff service’s clerical roots for the current state of play.
"Really, an MSP is not a secretary," Warstler says. "What we’re asked to manage on a day-to-day basis is so complicated.” She points to MSPs’ numerous potential areas of expertise and influence, which include regulatory and legal compliance, medical education, IT, data management, recruitment, marketing, organizational politics, and interpersonal communication. MSPs can use the NAMSS resources to educate decision-makers on the array of high-level duties they regularly perform.

Having the research and language to substantiate MSPs’ multidimensional value can aid appeals for competitive compensation as a means of recruiting and retaining quality talent, says Warstler. Targeted education can also streamline the daily workflow, challenging the tendency to route physician-related miscellany to the medical staff services department.

"If people don’t know where to give a duty to and it kind of relates to a physician, they give it to the medical staff office, and our job is really not to be the catchall,” says Warstler.

Warstler hopes the future will hold more consistent acknowledgement of MSPs’ expertise and important contributions to quality care, patient safety, and their employer’s financial health. “I’d really like to see the profession have a seat at the strategic table,” she says.

**Standardize roles and responsibilities**

Currently, facility-specific factors like location and size too often dictate the degree of respect MSPs receive—and the volume of responsibilities they shoulder, says Warstler. Integrating the NAMSS report’s core competencies in departmental organization is one way to promote uniform professional recognition from within. During the next revision of her department’s job descriptions, Warstler plans to shore up position-specific competencies with verbiage from the report.

“I really want to use that as a foundation for our job descriptions so that we’re on the same page as NAMSS,” she explains, emphasizing the importance of standardization in elevating the profession’s standing. See Figure 2 for UH’s competency requirements for a medical staff services and credentialing coordinator.

MSPs can also use the report to build an internal promotion structure or to retool an existing one. Through UH’s medical staff services and credentialing career ladder, which Warstler kicked off four years ago, an entry-level hire begins as either a credentialing assistant or credentialing quality control specialist and can work his or her way up the departmental rungs as a medical staff services and credentialing coordinator, analyst, and team lead. MSPs who demonstrate exemplary skill in a role can advance to a senior level, which comes with more responsibility and a higher salary.

Promotion is contingent on the employee’s ability to meet a number of performance benchmarks and requirements. That’s where the NAMSS report comes in handy, says Warstler, who will be reviewing criteria for advancement to ensure they reflect the constellation of competency areas present in the report. The alignment is already strong, she notes.

For example, one of the requirements for a UH credentialing assistant to advance to a senior credentialing assistant is participation in the development of two medical staff policies and/or privilege forms, a directive that corresponds to the NAMSS report’s core functional area of “Conduct, Participate In, and Maintain Current Clinical Competency Evaluations and Peer Review.” The career ladder task requires candidates to research minimum qualifications to perform a given procedure or scope of practice, which is a key aspect of managing current clinical competency evaluations, says Warstler. See Figure 3 for the complete career ladder criteria for advancing to senior credentialing assistant.

Beyond formal uses, MSPs should see the NAMSS resources as justification for tooting their own horn, says Warstler, who considers self-advocacy another key to wider acknowledgement.

“Our job as MSPs is to continually educate people about what we do, the special niche knowledge that we do have, and the value that we bring to the organization,” says Warstler. "We really are the front door to patient safety, so I think we just have to keep talking about it.”
Figure 2: Sample competency requirements

Job-specific competencies: Medical staff services and credentialing coordinator

<table>
<thead>
<tr>
<th>Competency</th>
<th>Job-specific competency: Medical staff services and credentialing coordinator</th>
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<tr>
<td><strong>Competency</strong></td>
<td>Analyzes and evaluates primary source verification data and documents for initial appointments and reappointments to the Medical and Allied Staff according to hospital and outside regulatory standards (Joint Commission, CMS, NCQA, etc.), as a function of the hospital’s risk management program for both hospital and delegated credentialing and hospital privileges. (40%)</td>
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| **Expectations** | • Processes applications in a timely fashion, analyzes data, identifies red flags and items requiring further review/additional information  
• Maintains credentials files in an orderly fashion  
• Maintains accuracy of medical staff database using consistent language for accurate reporting  
• Maintains current status for licensure, DEA registration, certifications, and professional liability insurance  
• Utilizes resources effectively, including the internet, while maintaining costs associated with credentialing  
• Appropriately interprets Joint Commission, NCQA, URAC, CMS, and other regulatory standards and applies this information to the credentialing and privileging process  
• Maintains open communication with applicants and Medical Staff leaders on a weekly basis  
• Maintains mechanism for communicating medical staff demographic and privilege changes within the organization  
• Prepares agendas for, attends, and records minutes for assigned meetings. Follows up as required  
• Demonstrates knowledge of regulatory standards that pertain to credentialing |
| Competency | Manages data quality and integrity for web-based applications based on defined standards through systematic audits. (20%) |
| **Expectations** | • Works collaboratively with health system departments and physicians to keep data up to date  
• Resolves problems as they arise  
• Responds to data requests  
• Independently coordinates systematic efforts to maintain data integrity  
• Recommends and initiates ideas for process improvement  
• Partners with physician leadership, administrative leadership, and others to create a culture of physician satisfaction  
• Prepares on-call schedules as assigned |
| Competency | Leads and manages practitioner performance evaluation process in accordance with Joint Commission Standards and Medical Staff Bylaws. (15%) |
Figure 2: Sample competency requirements (cont.)

**Expectations**

- Works collaboratively with Department Chairs to develop Focused Professional Practice Evaluation standards and criteria
- Works collaboratively with Department Chairs to develop Ongoing Professional Practice Evaluation standards and criteria
- Evaluates documents to determine if additional information is needed, follows up if/as appropriate
- Ensures compliance with Joint Commission Standards and Hospital policies relative to provider evaluations

**Competency**

Partners with Medical Staff Leaders to develop policies, evaluation standards, and privilege forms based on regulatory changes or hospital service changes. (15%)

**Expectations**

- Works collaboratively with Department Chairs, Human Resources, Nursing, Corporate Compliance, Legal, Board Members, and/or Board Certification agencies and outside agencies as needed to develop policies and/or privilege forms and criteria
- Processes policy and/or privilege form changes through the approval process defined by hospital policy or Medical Staff Bylaws, as applicable
- Interprets Medical Staff Bylaws, Rules and Regulations, Joint Commission Standards, NCQA regulations, and applicable sections of the Ohio Revised Code to ensure policies and privilege forms conform to applicable standards
- Serves as point of contact for new physicians to assist with onboarding issues
- Assists in designing communication tools to complement the medical staff orientation program for system facilities
- Creates and manages medical staff electronic distribution lists
- Meets with assigned Chairs on a quarterly basis to facilitate onboarding and privilege development processes

**Competency**

Liaises with Board Members, Senior Leaders, and outside agencies (e.g., the State Medical Board, the National Practitioner Data Bank, Board Certification agencies, the Drug Enforcement Agency, and malpractice insurance carriers). (10%)

**Expectations**

- Participates in regulatory/accreditation surveys, as requested
- Provides credentialing information to Board Members, as requested
- Serves as a liaison with outside agencies to assist new physician with obtaining licensure, board certification, malpractice insurance, DEA certificate, etc.
- Demonstrates knowledge of what is and what is not reportable to the National Practitioner Databank

Source: University Hospitals in Cleveland. Published with permission.

Site exclusive! Visit the Resources section of the CRC website to view University Hospitals’ full job description for a medical staff services and credentialing coordinator.
Figure 3: Sample career ladder requirements

Credentialing Assistant
Requirements to be eligible for consideration for promotion to Senior Credentialing Assistant are as follows:

- Two or more years in Credentialing Assistant role, or equivalent as determined by the manager.
- Written recommendations—one customer and one Medical Staff Services and Credentialing Department leader (manager or above).
- Successful coordination of one system/large-scale medical staff meeting/event per year.
- One presentation to the system-wide department group.
- Participation in the development of two medical staff policies and/or system privilege forms.
- Demonstrated ability to train others on Credentialing Assistant tasks.
- Participation in one external professional organization related to medical staff services and/or credentialing.
- Completion of five hours of yearly job-specific continuing education (20% must be external).
- Demonstrates high level of achievement for performance expectations/accomplishments/behaviors and requirements of the Credentialing Assistant role.
- Associate degree, or currently enrolled in a program. May substitute a certification that is applicable to role for an associate degree (e.g., CPCS, MSOW, Microsoft).
- Application through presentation of a formal portfolio.

Source: University Hospitals. Published with permission.

Visit the Resources section of the CRC website to view University Hospitals' full career ladder program documentation.
Stay out of legal hot water when clinical privileges expire

There may be times when a hospital knows it’s not going to get a physician’s reappointment application processed before his or her privileges expire. This could be for any number of reasons, such as the physician just never got around to completing the application or the person in the medical staff office who processes applications has been out due to illness. Or it could be the result of a more serious issue like a breakdown of the privileging process. There may be other times when a practitioner’s privileges have expired and it is discovered well after the fact. Whatever the situation or reason, hospitals need to weigh their options for handling expiring or expired practitioner privileges to avoid ending up in a legal jam.

Before privileges expire

When it’s discovered that a physician’s privileges are set to expire and there isn’t enough time to get his or her reappointment application processed in time, a hospital may choose to grant the practitioner temporary privileges to buy time. Hospitals can typically justify this course of action if the physician is currently practicing and fulfilling a patient care need that no one else can, as long as the bylaws allow, says Kathy Matzka, CPMSM, CPCS, a healthcare consultant based in Lebanon, Illinois.

Granting temporary privileges in this circumstance, however, comes with its own risks as the action might not meet accreditors’ standards. At the recent National Association Medical Staff Services (NAMSS) educational conference, Matzka posed the question to a Joint Commission surveyor, who stated it would not be appropriate to grant practitioners temporary privileges when there isn’t enough time to process their applications before their privileges are set to expire.

Despite this guidance, some hospitals with no other options may still decide to go this route, especially if they have language in their policies that states temporary privileges may be granted if there is an important care need and no one else can care for the patient in question.

“You’ve got to weigh what’s more important, getting the patients taken care of or whether or not you could be potentially cited by a surveyor for granting temporary privileges. I think ultimately what a hospital has to do is determine what is the best thing to do for patients,” Matzka says.

If granting temporary privileges is not a viable option, another route a hospital may choose to take if it has identified a reappointment application that won’t make it to the board by the deadline is to have its governing body grant a short period appointment.

“If your bylaws say appointments are only for two years, you can’t exceed two years by granting an extension. So what you would be doing is [providing] a new grant of clinical privileges and appointment, and you would give it to [practitioners] for a short period of time, usually one or two months, or however long it takes to get that application to the board for its approval,” Matzka says.

The process for a short period appointment is the same as the regular appointment process, requiring approval by the department chair and the medical executive committee before presentation to the board.

Once the request is before the board, explain the circumstances that have led to making the recommendation and ask for the board to approve the appointment.

“If the practitioner is already working at your hospital, and they’re doing a good job, you’re going to have your ongoing quality assessment improvement activities to support the recommendation,” Matzka says. Then again, if the evidence shows the practitioner has had little or no activity, poor outcomes, or is generally not a good provider, it may be best to consider other options, such as letting the privileges and appointment expire.
**Retroactive privileges**

What an organization can do if it discovers a practitioner’s privileges have expired is up for debate. For instance, there’s some difference of opinion about the use of retroactive privileges. Hospital may decide to use them if a practitioner’s recredentialing is missed, and it’s discovered that he or she has been treating patients for some time without clinical privileges. The idea is that when the practitioner’s application is brought to the governing board for approval, the board would make the appointment retroactive to the date the privileges expired to cover that gap.

Representatives from The Joint Commission, DNV GL, and Healthcare Facilities Accreditation Program were asked at the NAMSS conference about retroactive privileges, and each said that from an accreditation standpoint, retroactive privileges shouldn’t be used, says Matzka.

However, some healthcare attorneys have suggested that hospital boards grant retroactive privileges. These attorneys, Matzka says, are concerned that any practitioners functioning without privileges could make hospitals vulnerable to fraud and abuse laws or corporate negligence claims. For example, CMS regulations state that a Medicare patient must be admitted by a physician who has medical staff privileges at the hospital. So if a physician is admitting patients without privileges, the hospital is not meeting those regulations. This leads to questions of whether this is technologically fraudulent billing for services, and if so, whether the hospital has to return the money.

Concerns over charges of fraudulent billing have only intensified due to a recent U.S. Supreme Court decision that could potentially bring more False Claims Act (FCA) cases against healthcare providers. In the case of Universal Health Services v. Escobar, the court upheld the implied certification theory of FCA liability. Under this theory, and generally speaking, providers who submit claims for Medicare or Medicaid payments and make specific representation about the goods and services they offer, may be held liable under the FCA where compliance with a regulatory requirement was “material to the Government’s payment decision,” and they failed to disclose any sort of noncompliance with the regulatory requirements because those representations could be considered misleading.

From a privileging standpoint, the implied certification theory could potentially apply if a facility advertises that a practitioner is on staff but his or her staff membership has expired. In this case, the facility is falsely representing to the public that the practitioner is on staff and has clinical privileges. The concern among hospitals is that FCA liability may occur if a practitioner is not in fact on staff and doesn’t have clinical privileges because he or she wasn’t recredentialed. To be clear, U.S. courts have not applied this theory to a similar privileging scenario.

So despite the fact that accreditors have said retroactive privileges should not be used, hospitals may still find themselves utilizing them to protect themselves from possible FCA violations. A hospital going down this route must make sure that it has very clear documentation of the rationale behind this decision and that the minutes reflect what was done, Matzka says.

Not everyone is sold on the idea of retroactive privileges. As a general rule, Brian Betner, an attorney at Hall, Render, Killian, Heath & Lyman, P.C., in Indianapolis, questions the value of their use. If a hospital discovers a physician’s privileges have expired and uses retroactive privileges to protect itself from professional liability or negligent credentialing claims, it would be rather straightforward for a plaintiff to prove a practitioner was without privileges for a given amount of time.

“If you peel the layer one step, you’ll see that [practitioners] were in fact not privileged on a given date, so what do you gain by using that date? If you go to the minutes, you can prove pretty quickly that they weren’t privileged,” Betner says.

From a safeguard standpoint, Betner instead suggests hospitals allow the facts to speak for themselves. A hospital can mount a better defense if it’s able to show that, even though a practitioner may have had his or her privileges lapse, the practitioner was treated as though he or she was a member of the medical staff.
with privileges—the practitioner still followed the quality assurance and performance improvement process, the OPPE process, etc. “So you’ve effectively integrated them into everything that everybody else has been subject to,” says Betner. “All you didn’t do was get them approved at the final board meeting or by the medical executive committee.”

**Don’t backdate**

Another option a hospital may be tempted to take when it discovers a practitioner’s privileges have expired is to backdate the records of the reappointment; however, Matzka and Betner both say this practice should be avoided for the most part.

“If you take an application to the board, and it’s after the privileges have expired, you can’t just go and backdate it at the date of the approval and say, ‘Okay, we’re putting a fictitious date on there,’ ” says Matzka. Then again, backdating may be okay in certain cases, such as if a recredentialing application is approved by the credentials committee, goes through medical staff approval, is on the board meeting agenda, and is then approved by the board on time but is mistakenly left off the meeting minutes.

“I’m confident backdating happens, and it’s probably more justified and defensible when it was on a technicality, and the applicant was otherwise properly recredentialed and somehow just got left off the list, or when a similar scenario arises,” Betner says.

If that’s not the case, one of the major risks hospitals need to keep in mind if they backdate is how the action will appear to judges and juries during litigation. Consider, for example, that a hospital fails to privilege a practitioner on the date services were rendered, and there’s an allegation over liability. If the hospital is accused of negligence because it failed to properly credential the practitioner and allowed a patient to be harmed, backdating may jeopardize the hospital’s defense.

If the hospital backdated and the backdating is revealed in the discovery process of litigation, that suggests the hospital is covering something up, which will amplify concerns over liability, Betner says. As a result, judges and juries are more likely to find hospitals liable when there appears to be a cover-up.

“Even though in the bigger scheme of things you may have been able to argue that you had sufficient quality safeguards in place—the renewal is more of a technicality, and you continued to monitor [the practitioner’s] care as if they were privileged—it looks bad, the optics are bad,” Betner says.

Given that liability often hinges on how systemic or organizationwide a breakdown is, a hospital that delivers a good faith argument is in a better position to defend against a claim, he adds. If the hospital can show it followed appropriate processes and the situation that brought forth the litigation was a one-time technical oversight, it has strong evidence for a good faith argument. If backdating were added to the mix, the hospital would have a weaker claim of good faith.

So if a hospital followed the majority of its credentialing activities—quality department review, credentials committee review, and medical executive committee review—and an applicant was approved at each step but just missed a technicality at the end with the board’s approval, Betner thinks the hospital has a good faith argument that although it didn’t technically renew the applicant, it did in fact did recredential him or her.

“I like that argument, particularly when you don’t backdate because, again, backdating suggests you’re covering something up,” Betner says.

Of course, the good faith argument only works if the hospital actually recredited the applicant and followed an established quality assurance process for looking at outcomes and process compliance. If a hospital didn’t have any semblance of OPPE or similar routine quality oversight that could function as a proxy safeguard, then it would be in a much worse position.

“You have bigger problems if you don’t have that and you backdate,” Betner says. “I always work under the assumption of what you do will be known, so why not function in a transparent capacity and appropriately build up all the safeguards you have in place?”
Plan ahead

In the end, the best way to avoid these situations in the first place is to start the recredentialing process early so you don’t find yourself up against a looming deadline or well beyond it. Matzka says it’s a good idea for hospitals to start sending out recredentialing applications four or five months before a practitioner’s privileges are set to expire.

It’s also a good practice to take applications to the board meeting prior to the expiration month or to at least set that meeting as your target date, she adds. That way, if a meeting is cancelled for any reason, you have a safety buffer built in. This is especially recommended for hospitals in states that face harsh winters.

“Let’s say that you have some applications that are expiring in January, and you live in an area where you get a lot of snow. You may find that January board meeting might get cancelled because of a big snow storm,” Matzka says. “So it’s always a good idea to plan on taking that recredentialing application to the board the month prior to when the privileges actually expire. And then you just make those privileges effective when they would normally expire.”

Some hospitals and medical staffs use auto-renew provisions in their bylaws to overcome scheduling issues; however, accreditation organizations do not approve of them, says Betner. Essentially, these types of provisions state that if an appointment is not completed for any number of predefined reasons, the practitioner will be deemed active until action can be taken on the application.

“I don’t think that’s all bad if you have an appropriate quality assurance process in place, but I do know the accreditors disapprove of it,” Betner says.

Legal insights

Legal and regulatory news roundup

Find out what’s happening in the world of federal healthcare regulations by reviewing some recent headlines from across the country.

Health system settles HIPAA violations

Care New England Health System (CNE) has agreed to pay $400,000 and enact a comprehensive corrective action plan to settle potential violations of the Health Insurance Portability and Accountability Act (HIPAA).

In November 2012, the U.S. Department of Health and Human Services Office for Civil Rights (OCR) received notification from Woman & Infants Hospital of Rhode Island (WIH)—a covered entity member of CNE—that unencrypted backup tapes of ultrasounds had gone missing, according to OCR. These tapes contained ultrasound studies of approximately 14,000 individuals and included protected health information, such as patient names, dates of birth, and Social Security numbers.

WIH provided OCR with its business associate agreement with CNE. The agreement had been effective since March 15, 2005, but was not updated until August 28, 2015. The agreement therefore didn’t incorporate revisions required under the HIPAA Omnibus Rule.

The OCR’s investigation found that CNE lacked an up-to-date business associate agreement with WIH, meaning WIH impermissibly disclosed HIPAA-protected patient information during that time.

As a result of the data breach, WIH entered into a consent judgment with the Massachusetts Attorney General’s Office in July 2014 and reached a settlement of $150,000. OCR found that this judgment sufficiently covered most of the conduct in the breach and chose not to include additional potential violations.

Radiologists file whistleblower lawsuit over hospital’s kickback scheme

Two radiologists filed a federal whistleblower lawsuit alleging that Bozeman (Montana) Health Deaconess Hospital engaged in a kickback scheme that aimed to make millions from fraudulent Medicare and Medicaid claims.
According to the lawsuit brought under the False Claims Act, Intercity Radiology, which contracted with the hospital, was considering opening an outpatient imaging center in 2002. By offering lower prices, better office hours, and faster service, the new center would have forced the hospital to charge lower rates for its services.

To protect its monopoly on radiology services, the lawsuit alleges that Bozeman Health instead convinced Intercity Radiology to create a joint venture, Advanced Medical Imaging (AMI). The hospital intended to refer all outpatients to AMI in exchange for kickback payments. Attorneys for Intercity Radiology initially expressed concerns that the arrangement violated the anti-kickback statute. Despite the warnings, the hospital lowered the amount it wanted to be paid for the referrals and pushed for the joint venture to proceed.

Home healthcare agency owner sentenced to 30 years in prison

Zafar Mehmood, the owner of four Detroit-area home healthcare companies, was recently sentenced to 30 years in prison and ordered to pay more than $40 million in restitution. In July 2015, Mehmood was convicted of four counts of healthcare fraud, one count of conspiracy to commit healthcare fraud, one count of conspiracy to pay and receive healthcare kickbacks, one count of conspiracy to commit money laundering, two counts of money laundering, and two counts of obstruction of justice.

The convictions stem from a fraud scheme in which Mehmood and his co-conspirators received more than $33 million in Medicare payments. According to evidence presented at his trial, Mehmood was involved in a scheme from 2006 to 2011 in which he paid cash kickbacks to obtain patients. The recruiters would pay patients to persuade them to sign up for home healthcare services provided by one of Mehmood’s companies. Mehmood also paid physicians to refer patients to his companies for unnecessary services.

Mehmood and his co-conspirators also falsified records to make it appear as though patients qualified for and received the services billed to Medicare. Proceeds from the scheme were also laundered through a co-conspirator’s shell company, according to evidence presented at trial.

Also, during his pretrial release, Mehmood stole incriminating documents seized by law enforcement authorities when he visited a U.S. Department of Health and Human Services Office of Inspector General facility to review evidence with his attorney. The documents were subsequently recovered by law enforcement agents from Mehmood’s jail cell.

St. Joseph Health pays $2 million to settle potential HIPAA violations

St. Joseph Health (SJH), based in Irvine, California, agreed to pay more than $2 million to settle claims it violated HIPAA when it allowed electronic protected health information (ePHI) to be accessible through the internet.

According to OCR, in February 2012, SJH reported that certain files it created containing ePHI had been accessible to the public via search engines, such as Google, since February 2011. SJH had purchased a server with a file-sharing application to store its files. When implementing the server, SJH failed to modify the application’s default setting, which allowed anyone with an internet connection to access the files.

OCR’s investigation found that SJH failed to examine and evaluate the functionality of the new server and file-sharing application once they were implemented. As a result, SJH potentially disclosed files containing ePHI of nearly 32,000 individuals, including patients’ names, health statuses, diagnoses, and demographic information.

OCR also concluded that SJH did not conduct an enterprisewide risk analysis, as required by the HIPAA Security Rule. SJH instead hired contractors to conduct a patchwork assessment of the risks and vulnerabilities to the confidentiality, integrity, and availability of ePHI.

In a statement announcing the settlement, OCR Director Jocelyn Samuels said, “Entities must not only conduct a comprehensive risk analysis, but must also evaluate and address potential security risks.
when implementing enterprise changes impacting ePHI … The HIPAA Security Rule’s specific requirements to address environmental and operational changes are critical for the protection of patient information."

In addition to the settlement payment, SJH will also adopt a comprehensive corrective action plan. The plan calls for SJH to:

- Conduct an enterpriseswide risk analysis
- Develop and implement a risk management plan
- Revise its policies and procedures
- Train its staff on the updated policies and procedures

Healthcare agency owner pays to settle kickback allegations

Reginald King, the owner and operator of Kansas City, Kansas–based Best Choice Home Health Care Agency, Inc., will pay $1.8 million to settle allegations he violated the False Claims Act by paying for referrals of Medicaid-covered patients.

From July 2010 through December 2014, Best Choice allegedly submitted claims to Medicaid for home and community-based healthcare services that were the result of a kickback arrangement. Under the arrangement, King paid Christopher Thomas $58,000 in kickbacks to transport patients from their homes to Best Choice.

In a statement, Principal Deputy Assistant Attorney General Benjamin C. Mizer, head of the Justice Department’s Civil Division, said, “It is critically important that we protect the integrity of government health care programs by ensuring that services are provided based on clinical considerations rather than the financial interests of those who refer patients for care.”

Since Medicaid is a jointly funded federal and state program, the settlement payment will be split, with the United States receiving about $1 million and the rest going to the state of Kansas.

The settlement payment also resolves allegations brought by Thomas under the whistleblower provision of the False Claims Act. Under the provision, whistleblowers are awarded 10% of the federal share of the settlement. Thomas, however, will receive $43,000, which is 10% of the federal share of the settlement minus the amount he received in kickbacks.

Q&A

Tackling today’s top credentialing and privileging challenges

Credentialing and privileging have long been keystones of quality care and patient safety. But as healthcare reform drives consolidation, integration, and value-based reimbursement, these perennial functions are taking on new forms, environments, and significance. The following Q&A spotlights major challenges—and solutions—for the modern practitioner vetting world.

Q What are some of the top allegations raised in negligent credentialing suits, and how can healthcare providers guard against them?

A The following are the most common assertions that underpin claims of negligent credentialing:

- Negligence in gathering information regarding an application for privileges (e.g., failing to obtain appropriate references or a report from the National Practitioner Data Bank)
- Negligence in verifying the accuracy of information regarding an applicant (e.g., failing to perform primary source verification of an applicant’s licensure or education and training)
- Failure to follow medical staff bylaws, policies, and procedures in credentialing a practitioner (e.g., failing to obtain a recommendation on a credentials application from a division chair when one is required under medical staff bylaws or policies)
• Failure to follow credentialing standards established by accreditation requirements, licensing entities, CMS rules and the Medicare Conditions of Participation, or other rules or regulations applicable to the credentialing process (e.g., granting temporary privileges in a manner that’s noncompliant with accreditation standards)

• Negligence in reasonably assessing and evaluating information gathered through the credentialing process (e.g., failing to review and consider an applicant’s malpractice history)

• Failure to appropriately deny, restrict, limit, or terminate privileges of an unqualified practitioner (e.g., granting privileges to a practitioner who does not meet the eligibility requirements to hold those privileges)

• Failure to take appropriate corrective action against a practitioner or to institute appropriate remedial action based on available information that was gathered or should have been obtained through the credentialing process (e.g., taking no action against a physician who chronically engages in significant unprofessional disruptive behavior)

The majority of these assertions fall into one of two camps:

1. Failure of procedure (e.g., neglecting to obtain required information or to comply with an accreditation standard)

2. Substantive shortcoming in the actual assessment of information and the resulting credentialing action (e.g., deciding to grant privileges to a doctor despite the fact that he or she had lost similar privileges at another hospital based on demonstrated incompetence)

Obviously, the best way to protect against the first type of allegation is to carry out credentialing with the meticulousness the process deserves. The best way to defend against the second type of allegation is to document that red flags were considered. For example, if a doctor’s application shows that he or she has several past malpractice actions, a good credentials committee will create a written record stating that it knew about and considered this information and considered it in reaching its recommendation.

Q Who contributes to credentialing and privileging for employed physicians?

A It depends, but regardless of the specific contributors, the process must be the exact equivalent of what is done for non-employed physicians. In most health systems, it makes sense for the medical staff services department (MSSD) to coordinate physician credentialing and privileging activities, as MSPs handle practitioner vetting information every day. The MSSD may be based at the local hospital looking for more guidance on modern credentialing and privileging quandaries?

Attend the 2017 CRC Symposium on April 6–7, 2017, in Austin, Texas, for two days of engaging education and training taught by the industry’s top credentialing and medical staff experts. During the event, MSPs, medical staff and physician leaders, and quality directors will learn actionable strategies for building compliant vetting processes and managing high-performing medical staffs.

Sessions include:

- Credentialing Advancements in a New Delivery Era: Real Results in Alignment Between Credentialing, Provider Enrollment, and Delegation
- Addressing Issues Related to Employed Physicians
- APP Challenges: Competence Assessment and Expanding Scopes of Practice
- The Growing Threat of Negligent Credentialing Litigation
- Privileging Conundrums

Click here to view the full agenda.
site and function autonomously, or it may be linked internally or externally with a credentials verification organization (CVO) owned by or contracted with the health system. Rarely, a hospital might not have an MSSD and instead delegate credentialing to human resources, but in that instance, the process must be exactly the same to meet the accreditation and regulatory standards of CMS’ Conditions of Participation. To be successful, ongoing communication and collaboration with all involved parties is essential.

Beyond the primary players, additional entities may require vetting information for employed physicians. The health system will need to obtain payer credentialing in order to receive revenue for rendered services. With the possible exception of an extremely confidential peer review reference obtained on a candidate, there is no reason not to share the verified information about training, licensure, and so forth with whomever handles payer credentialing in your organization. (In fact, some MSSDs now perform this function in addition to medical staff credentialing.) Human resources needs information, as well, in order to process the employment application.

Q  What are some potential focus areas for advanced practice professional (APP) task forces?

A  One method of integrating APPs into their roles and responsibilities is to form a dedicated task force. This body, which should comprise representatives of each key APP discipline and stakeholder group, can contribute to the following activities, under the supervision and guidance of the medical staff committees and respective department chairs:

- Development of ongoing and focused competency assessment criteria for each APP discipline (e.g., physician assistant, nurse practitioner). Some facilities already obtain this type of information from APPs who are part of a contract group. For example, anesthesia and emergency medicine are contract services. These services often have outside contractual assistance with ongoing competency assessment data, which can be provided to your facility.

- Review and revision, as needed, of privilege forms, based on current criteria.

- Assistance with review of appointment and reappointment files. Just as the appropriate privileged practitioner should be responsible for reviewing like files, so should the APP be involved in appropriate review.

- Review and revision, as appropriate, of existing APP rules and regulations.

- Potential assistance with behavioral/clinical practice concerns relative to individual APP performance. When a case is presented to peer review that involves the APP as well as the physician, APP education and collaboration should also be completed, along with medical staff education. These activities should then become part of the practitioner’s ongoing competency assessment and peer review file, for consideration at the time of reappointment.

- Collaboration with key medical staff members on a “team approach” for patient care (e.g., the role of the APP versus the role of the physician). Some hospitals have team-approach patient rounds that include physicians, APPs, and ancillary and nursing staff.

- Attendance at credentials committee meetings when APP files are being reviewed for privileges.

Although the ultimate responsibility for these activities will lie with the medical staff, medical executive committee, and board, APPs’ input is invaluable. A dedicated task force also gives more credence to these practitioners, which may result in more collegiality and improved understanding of each other’s roles. It will also make life a little easier for the MSP, who must make sure that monitoring occurs for all of the previously-discussed APP requirements.

EDITOR’S NOTE
This article was adapted from several HCPro medical staff and credentialing books: Negligent Credentialing; The Medical Staff’s Guide to Employed Physicians; and Resolve Practitioner Turf Conflicts. For more information or to order, visit www.hcmarketplace.com/subject/medical-staff.
Building a successful delegated credentialing partnership

by Laurel J. Yungwirth, CPCS, MHA

About five years ago, my employer, Allegheny Health Network (AHN), decided to pursue delegated agreements with the big-name insurance companies in our area. AHN, which comprises seven hospitals and four ambulatory surgery centers throughout Pennsylvania, was looking for ways to increase revenue and reduce the number of delivered services that were later deemed ineligible for reimbursement.

For the uninitiated, delegated credentialing is a formal agreement between two organizations in which one partner gives the other permission to perform credentialing functions on its behalf. This kind of arrangement is typically between an insurance company and a healthcare institution.

At AHN, we quickly learned that building such a relationship is a significant undertaking, and after audits with five potential partners revealed disparities between our existing processes and those required for a delegated credentialing arrangement, only one health plan was willing to move forward.

This insurance company recognized that we had never previously needed to adhere to the requirements set forth by health plan accreditors (the National Committee for Quality Assurance [NCQA] and the Utilization Review Accreditation Commission [URAC]). Plus, based on our diligence in following the policies, procedures, and regulatory requirements already in play at our organization, the company trusted in our ability to adapt to its standards.

Still, before finalizing the agreement, the health plan directed us to alter our existing policies and procedures to meet NCQA standards. The company’s contact person was willing and able to answer any questions we had and ultimately helped our network develop the governing materials that we have in place today. I also played a big part in the early rollout, reviewing initial appointment and reappointment files before the monthly credentials committee meeting to ensure they complied with the new delegated requirements.

Fast forward five years, and the health plan’s decision to contract with us proved a sound investment. Today, AHN has a smooth delegated credentialing process and enjoys a strong, collaborative partnership with the insurance company. We still reach out with questions regarding changing requirements and receive friendly support that helps both organizations succeed. Now, armed with delegation-ready policies and procedures, AHN is well-positioned to pursue agreements with additional insurance companies.

My role in cultivating and maintaining our first delegated credentialing arrangement has taught me a lot about the nuts and bolts of a successful partnership. Here are some key takeaways.

Why pursue delegated credentialing?

In a delegated credentialing relationship, a healthcare organization completes the primary source verifications necessary for a practitioner to enroll with the health plan. This activity, which must be performed in accordance with the regulatory and accreditation requirements governing both partners, allows the insurance company to use the healthcare organization’s files without completing the verifications firsthand.

Beyond the obvious perks for the health plan, a delegated credentialing arrangement can produce many benefits for the healthcare system, including the following:

• Less repetitive paperwork for new employees and practitioners
• Faster enrollment with insurance companies
• Fewer denied claims stemming from failure to complete the insurance company’s credentialing
process before practitioners begin providing care within the facility

Who should pursue delegated credentialing?
While delegated credentialing can be beneficial for both parties involved, there are certain organizational factors that healthcare institutions should consider before seeking out such arrangements.

Delegated credentialing is often best for organizations that manage health plan enrollment and service reimbursement for a significant number of practitioners. If your employer’s affiliated provider population is primarily composed of private practitioners whose enrollment and reimbursement functions are carried out elsewhere, then delegation may not be worth pursuing.

Each partnership is different, and the only way to know whether a potential agreement is viable is to ask the right questions and obtain specific details from the insurance company. Discussion topics can range from provided services and facility types to previous contracts and agreements, so make sure all relevant bases are covered.

What should we expect during a pre-delegation audit?
When an organization decides to pursue a delegated agreement with an insurance company, it must adapt existing processes to meet the additional requirements posed by the health plan’s regulators and accreditors. Oftentimes, potential partners will assess a healthcare facility’s compliance with these standards through a pre-delegation audit.

During the audit, healthcare facility staff will need to know their current policies and procedures inside and out to confirm that all relevant requirements are addressed. In addition, you may need to demonstrate that current files and completed verifications meet these standards. Prior to the visit, I recommend requesting that the health plan provide a list of file elements and verbiage of interest to the auditor to ensure preparedness.

How do we adapt our existing processes?
One of the most important steps in readying internal processes for a new delegated credentialing arrangement is ensuring all employees involved in credentialing and payer enrollment understand the rationale behind the new requirements. If managers are the only ones in the know, the staff members who are actually processing the files may overlook the new expectations and continue doing things the way they have always been done.

Before explaining all of the changes to their team, upper management and other implicated departments (e.g., finance, those involved in managing the delegated agreements) should compare their current processes to the relevant NCQA or URAC standards. Next, they should determine what changes are necessary to meet the new requirements.

Consider developing a cheat sheet that all employees can reference until they get into the habit of performing the additional tasks.

When developing new processes, managers must avoid creating duplicative work for their team. If your department already completes part of a task required for a new delegated arrangement, update the existing approach as necessary to comply with both sets of expectations at once (e.g., NCQA requirements for delegated credentialing and Joint Commission standards for traditional credentialing). Always ensure you’re meeting the strictest set of standards.

EDITOR’S NOTE
Yungwirth is an associate credentials systems specialist at the Allegheny Health Network, based in Pittsburgh.
With a dynamic learning structure, first-class faculty, and an unparalleled platform for networking with peers, the 2017 CRC Symposium is unlike any other industry event!