POLICY STATEMENT

The Medical Staff Office coordinates the credentialing process of all prospective members to the Medical and Allied Health Staff for AU Medical Center. Collection of all application forms and supporting documentation, verification of all required credentials, maintenance of a credentialing database system and communications are handled by one office. This one office supports credentials committee review and recommendations for appointment/reappointment and privileging in each hospital within the healthcare system. The AU Medical Center Medical Staff Office does not sub-delegate any credentialing functions to an outside source. The recommendations of the hospital’s Credentials Committee and Medical Executive Committee are reported to the Board of Directors (Governing Body). Therefore, in order for there to be uniformity of credentials documentation and information and to reduce the burden of overseeing the application process, all credentialing information will be shared within AU Medical Center. Credentialing information is peer review protected and all new members of peer review committees (such as Credentials Committee, Medical Executive Committee, PI Peer Review) will be oriented to the confidentiality process and will sign a confidentiality agreement. All information obtained during the initial and re-credentialing process is confidential. PHI is not used in the credentialing process but if submitted with the application, this information is destroyed, returned or blinded.

The hospital Credentials Committee and Medical Executive Committee will review this policy annually. Upon final approval the policy will be submitted to the Board of Directors of AU Medical Center for approval.

The Medical Staff Office will maintain minutes of the Credentials Committee and Medical Executive Committee meetings.

AFFECTED STAKEHOLDERS

Indicate all entities and persons within the Enterprise that are affected by this policy:

☒ Administrative Services
☒ Hired Staff
☒ Housestaff/Residents & Clinical Fellows
Leased staff
Medical Staff (includes Physicians, PAs, APNs)
Patient Care Services (Nursing, PCT’s, Unit Clerks)
Professional Services (Laboratory, Radiology, Respiratory, Pharmacy; etc.)
Vendors/Contractors
Other: Locum Tenen practitioners

DEFINITIONS

To establish a standardized procedure for reviewing and approving the qualifications of physicians (M.D., D.O. or equivalent), dentists (D.D.S. or D.M.D.) and Allied Health providers (APRN, PA, CRNA, CNS, CNM, DA) including administrative officials who request medical staff membership or clinical privileges in the AU Medical Center. In addition, this policy will be utilized to review and approve those practitioners who are not members of the Medical Staff but are licensed, independent practitioners (psychologists, podiatrists, optometrists and chiropractors).

SCOPE

The responsibility and authority for appointing and re-appointing medical and allied health staff members and for granting, renewing, or revising hospital-specific clinical privileges rests with the Board of Directors of the AU Medical Center. The Chief Medical Officer is responsible for the oversight of the credentialing program. Credentialing policies and procedures are established to meet/exceed The Joint Commission (TJC), the National Commission on Quality Assurance (NCQA), the American Accreditation HealthCare Commission (URAC) standards and all Federal and State regulations. Standardized credentialing forms are approved by the Medical Staff Executive Committees and they are used to guide the credentialing process. This policy is in compliance with the Medical Staff Bylaws and Rules & Regulations of AU Medical Center. The organization does not make credentialing and re-credentialing decisions based on an applicant’s race, ethnic/national identity, gender, age, sexual orientation or the types of procedures or patients in which the practitioner specializes. Each member of the Credentials Committee will sign a Non-Discrimination statement. The composition of the Credentials Committee includes representation from a range of participating practitioners in the network. Periodic audits of practitioner credentialing complaints will be conducted no less frequently than annually to determine if there are complaints alleging discrimination. Audit results will be reported to the Credentials Committees. All primary source verified information on each provider is entered into the MD Staff database and used to create rosters to share with the health plans that AU Medical Center has a delegation relationship with.
PROCESS & PROCEDURES

INITIAL APPOINTMENT & INITIAL GRANTING OF PRIVILEGES:

An application for appointment to the medical or allied health staff, supporting documentation requirements and a current copy of Bylaws and Rules and Regulations are provided to the applicant by the Medical Staff Office either by paper copy or via internet/intranet. A faculty appointment to the Augusta University Medical College of Georgia is required to participate in the teaching program and it is desirable but not required for medical or allied health staff appointment or clinical privileges. According to Medical Staff Bylaws the entire appointment process must be completed within 180 days of the date the application is initiated (signed).

Responsibility of Applicant: The applicant is responsible for completing the application forms and providing copies of all required documentation. If an error is made on any of these documents, the applicant is requested to strike the error with a single line and initial. White-out, correction tape or other means of correction products will not be accepted. Generally the application must be returned to the Medical Staff Office within 30 days. Required primary source verification is a time consuming task that routinely takes 60 to 90 days in some cases. The following must be forwarded to the Medical Staff Office prior to a file being submitted to the Credentials Committee, and would constitute a complete application:

- Complete, signed and dated Medical or Allied Health Staff Appointment Application form. The applicant shall include an attestation, dated and signed by the applicant, for completeness and accuracy.

- As part of this application, the following information must be provided:
  i. Previously successful or currently pending sanction to any licensure or registration, or voluntary relinquishment of such licensure or registration;
  ii. Voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital;
  iii. Involvement in a professional liability action. At a minimum, the applicant is requested to provide final judgments or settlements.

- Completed specific Delineation of Privilege form.

- Current ATLS/ACLS/PALS certification is required at all times if sedation privileges are requested.

- Copy of current curriculum vitae. (C.V. must include month/year for education and work history with no gaps since medical or graduate school). The Medical Staff Office requires that all gaps over 30 days be explained in writing.
• Copy of current Georgia state medical license and other state licenses.
• Copy of medical or graduate school graduation diploma, if applicable.
• Copy of internship, residency, fellowship or specific training certificates, if applicable.
• Copy of board certificate(s), as applicable.
• Copy of ECFMG certificate, if applicable.
• Copy of current DEA. This includes South Carolina DEA and CDS certificate, if applicable.
• Copy of current insurance certificate (in the amount of at least 1M/3M).
• Copy of Permanent Resident Card or Visa Status, if applicable.
• One recent passport size photograph (passport photos should be in color and within the last 6 months).
• Military Discharge Record (Form DD-214) if applicable (discharged in the last 5 years).
• Copy of Social Security card.
• Copy of signed Protocol Agreement between an APRN and Delegating physician and any alternative Designating physicians; Copy of letter from GA Medical Board approving the Delegating Physician is also required.
• For PA’s a copy of the letter from the GA Medical Board approving the Supervising Physician with copies of approved alternate physicians is required.
• Copy of current passport or a current and valid state driver’s license. If the applicant does not wish to copy one of the above documents, he/she may present a current passport or current and valid state driver’s license in person to the Medical Staff Office and verification will be recorded in the file. However, the application packet will not be forwarded to the Credentials Committee until this verification has been recorded.
• Copy of Tuberculin Skin test or QuantiFERON®-TB testing documentation.
• Completed Criminal History record release form.
• Three (3) peer evaluations will be required. These will be sent to current peers who can attest to the applicant’s qualifications. For allied health providers, one peer evaluation must come from their current supervising/collaborating physician. For new graduates, one must come from the Program Director.
• A two (2) year clinical history of procedures or activity log performed from your primary work site. An interview(s) may be required if this cannot be provided.
• Completed Intended Practice Plan for community physicians.

• Adequate physical and mental health of the practitioner is required to be a member of the medical staff. The Credentials Committee may request documentation of adequate physical and mental health at initial appointment, renewal or for cause. This documentation may be requested from internal and/or external sources as required by the committee.

• Sign and date administrative forms to include: Electronic Signature Form, Hand Washing Statement, Data Validation Information, Attending Physician Responsibilities and Affirmation Forms, Conflict of Interest Form, Attestation Statements for Restraint/Seclusion and Pain Management Policies and Patient and Family-Centered Care Principles and Behavioral Standards Commitment and Re-Commitment form.

The applicant also:

• Agrees to abide by the Bylaws, Rules & Regulations and policies & procedures of the Medical Staff (by signing the application).

• Consents to the querying of records and documents pertinent to licensure, training, experience, current competence, and ability to perform the privileges requested, and to appear for an interview, if requested.

• Pledges to provide for the continuous care of his/her patients (across covering system).

Responsibility of Medical Staff Office: A separate file is maintained for each individual requesting medical staff membership or clinical privileges. Practitioners' files are maintained in secure, locked file cabinets to assure confidentiality. The Medical Staff Office maintains appropriate security. A Confidentiality Statement is maintained for every individual who is allowed access to specific physician credentialing information. Persons required to sign a Confidentiality Statement include but are not limited to the Medical Director, the President of the Medical Staff, all Medical Staff Office personnel, members of the Credentials Committee, immediate and upper level supervisors and any outside reviewer such as a managed care auditor.

The Medical Staff Office verifies through primary source that information provided by the applicant is true and accurate and obtains additional information detailed in this section. Information is collected no more than 180 days prior to the Credentials Committee review of the application. Good faith attempts, at least three, are made to obtain primary source information and the burden is on the practitioner to help facilitate this process. In those rare cases where primary source verification is excessively difficult or impossible to obtain (due to hospital closure, acts of war, natural disaster, cessation of business entities, foreign training or employment etc.), verification from carefully selected secondary sources or third parties will be sought. Such information will be flagged, discussed and approved by the Credentials Committee Chair or Chief Medical Officer prior to submission to the Clinical Service Chief. The Medical Staff Office
completes this process and forwards the file to the Clinical Service Chief of the applicant’s specialty for review and endorsement. No appointments or clinical privileges are forwarded to the Credentials Committee until all required information is verified. Applicants are given the opportunity to check the status of their application and to respond to any information obtained by the Medical Staff Office that varies substantially from that provided by the applicant during the credentialing process. Applicants are informed of their right to review information via the attestation form within the application. Any discrepancies found between information provided by the physician and information obtained through primary source verification will be brought to the attention of the practitioner so that he/she may correct any erroneous information. The practitioner will be notified either in writing via email or by telephone and given ten (10) business days from the date of the letter to respond in writing or verbally to the Medical Staff Office. The applicant will be notified via email or by telephone when the corrected information has been received and verified. Practitioners may review information obtained by the facility from a primary source entities such as malpractice insurance carriers, National Practitioner Data Bank (NPDB) and licensing boards; they cannot review information that is peer review protected.

Current licensure status and expiration date must be verified electronically, verbally or in writing with the Georgia Composite Medical Board, the Georgia State Board of Dentistry, Georgia Board of Nursing or appropriate Georgia state board and from any state licensing board where an active or inactive license has been held in the past five years. The Federation of State Medical Boards may also be queried to facilitate this process. South Carolina Medical Board will be queried on all practitioners.

Any practitioner who requests Point of Care/Waive testing is required to complete periodic competency assessments.

Current DEA certificates will be verified with National Technical Information Service (NTIS). South Carolina CDS will be queried on all practitioners. If a new applicant has a DEA from another state other than Georgia at the time the application is presented to the Credentials Committee, a Faculty member from the hiring department will need to write a statement of responsibility for prescribing until the applicant has updated their DEA to reflect a Georgia address.

Relevant training or experience including graduate school, medical school, internship, residency, fellowship training and board certification must be verified through primary source. Acceptable sources include:

- Direct from the source, electronically, verbally or in writing.
- AMA Physician Master file.
- AOA Physician Master file (for D.O.’s)
- National Student Clearinghouse
• ECFMG (for foreign medical graduates).

• American Board of Medical Specialties (ABMS) and other boards accepted by the Credentials Committee, i.e., American Board of Podiatry.

• Education must match the requested specialty either by completing a Fellowship or by Board Certification.

Practice/work history is verified by:

• Sending an evaluation form to the most recent previous practice site.

• Sending a hospital verification form to previous hospitals.

• Other inquires as needed.

Current competence is verified by the Medical Staff Office by obtaining information directly from the primary source in the form of a peer evaluation to those personally acquainted with the applicant’s professional and clinical performance. A list of privileges requested is attached to the evaluation for a recommendation. Three (3) peer evaluations are requested and required by responsible practitioners. This can include references listed in the application or others chosen at the discretion of the Medical Staff Office. Telephone and/or email follow-up is performed as needed.

Ability to perform privileges requested is attested by the statement of the applicant in the application and must be verified by the director of the training program (for new graduates) or by a qualified peer who can attest to current competence. The Credentials Committee reserves the right to seek outside and/or additional guidance regarding the competence of any medical staff member to perform privileges requested.

Health status - For applicants greater than 65 years at appointment, a physical examination is required. For applicants greater than 70 years of age, a physical exam including a neurological assessment by a neurologist is required. These examinations may be provided internally, externally or both as required by the committee.

Verification of liability insurance in the amount of at least $1 million/$3 million dollars is required. Insurance verification is obtained from all current or previous insurance carriers for past 10 years, if obtainable, lifetime claims history and information on any current and/or pending claims. The Medical Staff Office will verify all current insurance for Medical Staff membership via one or more of the following methods:

• Department Of Administrative Services (DOAS) – Medical Staff with faculty appointment for which the practitioner is paid by Augusta University and insured by DOAS.

• AU Medical Associates (AUMA) – Medical Staff who is employed by GRMA for which the practitioner is paid by GRMA are insured by GRMA.
• Practitioners associated with neither Augusta University nor AUMA (Community Physicians) - The current insurance company must be financially sound and licensed in Georgia. Each practitioner is required to maintain such insurance and shall provide a certificate of insurance (which shall include agreement of the insurer to notify AU Medical Center in the event of cancellation).

• For military physicians, the current commanding officer is queried for a lifetime claims history.

National Practitioner Data Bank (NPDB) is queried to determine (if applicable):

• Medical malpractice payments.
• Licensure disciplinary actions for all health related professions including those outside of medicine.
• Adverse clinical privilege actions taken by a health care entity.
• Adverse actions affecting professional society membership.
• Adverse licensure and certification actions for all health related professions including those outside of medicine.
• Exclusions from participation in federal and state healthcare programs.
• Convictions and civil judgements related to healthcare.

Medicaid/Medicare Sanctions are verified through the Internet by reviewing the Sanctions & Reinstatement Report through the Office of Inspector General (OIG) website. The OIG website is also queried each month for Exclusions and Re-instatements, printed and kept in a binder in the Medical Staff Office. If a GRU practitioner is reported, the Chief Medical Officer and Clinical Service Chief are notified immediately. The South Carolina Excluded Practitioner list will also be queried. System for Award Management (SAM) and the Medicare Opt-Out for Georgia lists are also verified through the Internet by querying their website.

Adverse findings: The Medical Staff Office notifies the Clinical Service Chief (s) of any adverse findings/actions found during the verification process. The Credentials Committee will also be informed during the verification process.

A criminal background investigation will be performed on all practitioners by completing the appropriate criminal background forms. The Medical Staff Office initiates a criminal background investigation with a contracted outside firm. The complete application, once endorsed by the Clinical Service Chief, is forwarded to the Credentials Committee for a recommendation.

The practitioner and the hiring department are notified in writing via email or by telephone that their initial application is incomplete. They are told what is missing and the timeline to complete the process. If the applicant fails to submit a completed application and required documents for initial appointment within 180 days of signing the application, the applicant shall be deemed to have withdrawn their request for an initial appointment with the Medical Staff. An email will be sent to the applicant and
hiring department to alert them that the initial application has expired and the process will have to be repeated.

**Responsibility of Service Chief:** The Clinical Service Chief reviews the complete and verified packet and makes a recommendation for initial appointment and granting of privileges. Criteria specified in the Bylaws constitute the basis for these actions and include evidence of current licensure, relevant training/experience, current competence, and ability to perform privileges requested. The Service Chief returns the endorsed application to the Medical Staff Office within seven (7) business days.

This includes:
- Completed application packet described above
- Recommendation of Clinical Service Chief for initial appointment
- Recommendation of Clinical Service Chief for delineation of privileges

If after seven (7) business days the Clinical Service Chief has not forwarded a recommendation on an application, the CMO and/or the President of the Medical Staff may forward the file to the Credentials Committee for action.

**Responsibility of Credentials Committee:** Members of the Credentials Committee review the complete and verified application and recommend to the Medical Executive Committee that the application be accepted, deferred, pended or rejected.

**Responsibility of Executive Committee:** The Medical Staff Executive Committee reviews and accepts, rejects, defers or pends the recommendations of the Credentials Committee. The CMO then presents the Credentials Committee’s recommendations to the Board of Directors.

**Responsibility of Governing Body:** The Board of Directors makes the final decision to approve/disapprove all recommendations. This must occur within 180 days (6 months) of the signing of the application by the applicant. Only the Board of Directors has the authority to approve/disapprove appointments/reappointments to the medical and allied health staff and/or to grant clinical privileges in the AU Medical Center. Applications that are not acted upon by the Board within 180 days are deemed to have been withdrawn.

**Provisional Appointments:** Initial appointments & privileges are provisional for a period of one year. At the end of the provisional period, the performance of the person shall be reviewed by the service chief and recommendations may be made to the Board of Directors. The Board of Directors may terminate the provisional status and extend the practitioner’s medical or allied health staff membership and clinical privileges for an additional year; they may extend the provisional status for an additional period of time up to one year, or terminate the practitioner’s medical or allied health staff membership and clinical privileges.
**Fair-Hearing and Appeal Procedures:** Whenever an adverse decision is made regarding an application for medical or allied health staff membership or clinical privileges, the practitioner may utilize the fair hearing and appeals process outlined in Article VI of the Bylaws. The National Practitioner Data Bank will be notified of any practitioner that meets reporting requirements as outlined in the NPDB guidelines.

**Notifications:** After approval by the Board of Directors the following are notified:
- The President/CEO and President of the Medical Staff notify the applicant of his/her approval in writing within 10 calendar days. An electronic notification goes out to all departments.

The Medical Staff Office provides:
- The Health Information Management Systems Department provider specific information to initiate issuance of a provider identification number.
- The list of privileges is entered into the credentialing computer database to which the appropriate practice sites have immediate access to view.

**REAPPOINTMENT AND RENEWING OR REVISING CLINICAL PRIVILEGES:**
Reappointment to the Medical and Allied Health Staff and the renewing or revising of clinical privileges is performed biennially. Failure to reappoint within twenty-four (24) months will result in the loss of hospital privileges. A faculty appointment to the Augusta University Medical College of Georgia is required for reappointment to participate in the teaching program and is desirable but is not required for medical staff reappointment or renewing or revising of clinical privileges. Physician-specific performance data provided by managed care groups in which the applicant is a participant are provided to the Service Chief to be incorporated into the departmental Quality files and are reviewed at least at the time of reappointment. Information from the Medical Staff Office is used to determine the schedule for reappointment. A report is generated to identify practitioners who are due for reappointment and to review their privileges. The Medical Staff Office notifies the practitioner and their respective Service Chief when reappointment is due. The Medical Staff Office provides the application form, instruction sheet, appropriate privileging forms, and access to the Bylaws and the Rules & Regulations to the practitioner. The completed application and supporting documentation must be returned to the Medical Staff Office within 4-6 weeks.

**Responsibility of Applicant:** The applicant is responsible for completing the following forms and providing copies of all required documents. These must be forwarded to the Medical Staff Office within 4-6 weeks. If an error is made on any of the paperwork, the applicant is requested to strike the error with a single line and initial. White-out, correction tape or other means of correction products will not be accepted. As part of this application, the following information must be provided or obtained:
- Completed Medical or Allied Health Staff Reappointment Application form. The applicant shall include an attestation, dated and signed by the applicant, of completeness and accuracy.

As part of this application, the following information must be provided or obtained:
- Completed specific Delineation of Privileges form.
• Current ACLS/ATLS/PALS certification is required if Sedation privileges are requested and must stay current

• Current curriculum vitae with updated information since the last reappointment.

• Current Georgia state license information and information on other current licensures.

• One recent passport size photograph (passport photos should be in color and within the last 6 months).

• NEW specialty board certification information (copy of certificate acceptable).

• Copy of current DEA.

• Copy of signed Protocol Agreement between an APRN and Delegating physician and any alternative Designating physicians; Copy of letter from GA Medical Board approving the Delegating Physician is also required.

• For PA’s a copy of the letter from the GA Medical Board approving the Supervising Physician with copies of approved alternate physicians is required.

• Completed Tuberculin Skin Test or QuantiFERON®-TB testing documentation

• Copy of current liability insurance policy in the amount of at least $1 million/$3 million dollars.

• Completed Malpractice Case Summary form for any liability actions from the previous two years.

• Documentation of continuing education (C.E.) for past two years (40) hrs. Twenty (20) CME hours must be within area of specialty. CME’s may be documented in the following ways: obtaining copies of program certificates; obtaining a copy of the information submitted with a license renewal application attesting to CME credits; or obtaining an attestation statement from the practitioner which attests to attendance at CME programs that relate to their area of practice (proof of attendance and program will be submitted upon request by the Medical Staff Office).

• A two (2) year clinical history of procedures or activity log performed from your primary work site.

• Two (2) completed peer evaluation forms. The peer evaluation form must include the phone number of the peer that completed the form. For allied health providers, one peer evaluation must come from their current supervising/collaborating physician.

• Completed Criminal History record release.

• Signed and dated administrative forms to include: Electronic Signature Form, Hand Washing Statement, Data Validation Information, Attending Physician Responsibilities form & Affirmation Form, Conflict of Interest Form, Attestation

- Adequate physical and mental health of the practitioner is required to be a member of the medical staff. The Credentials Committee may request documentation of adequate physical and mental health at initial appointment, renewal or for cause. This documentation may be requested from internal and/or external sources as required by the committee.

- For applicants greater than 65 years at reappointment, a physical examination including mental competency is required. For applicants greater than 70 years of age, a physical exam including a neurological assessment by a neurologist is required. These examinations may be provided internally, externally or both as required by the committee.

Responsibility of Medical Staff Office: The Medical Staff Office verifies the following information provided by the applicant through primary source. No reappointment or renewal or revision of clinical privileges is recommended for approval until required information is available and verified. Information is collected no more than 180 days prior to the Credentials Committee review of the application. Once the verification process of the reappointment file is completed the Medical Staff Office presents it to the Clinical Service Chief for review and recommendation for approval.

The Medical Staff Office verifies:

- Current licensure status and expiration date are verified electronically, verbally or in writing with the Georgia Medical Board, SC Medical Board, Georgia Board of Nursing or the Georgia Board of Dentistry. The Federation of State Medical Boards may also be queried to facilitate this process. A license sanction/limitation report is also received from the Georgia Medical Board following their Board Meetings and is reviewed and maintained in the Medical Staff Office.

- Current DEA certificates will be verified with National Technical Information Service (NTIS). South Carolina CDS will be queried on all practitioners.

- Any practitioner who requests Point of Care/Waive testing is required to complete periodic competency assessments.

- Relevant training or experience – any new specialty certification will be verified with the primary source.

- If the physician holds current hospital privileges with other facilities, the status of those privileges will be verified.

- Current competence is verified by the recommendation of the Service Chief, which is based on a review of performance improvement activities and outside performance data maintained in quality files and peer recommendations.
• Ability to perform the privileges requested is documented through the applicant's statement and the Service Chief’s countersignature.

• The Medical Staff Office initiates a criminal background investigation with a contracted outside firm.

• Verification of liability insurance in the amount of at least $1 million/$3 million dollars is required. Insurance verification is obtained from all current insurance carriers. A two-year claims history and information on any pending cases must be provided. For military physicians, the current commanding officer is queried for the claims history.
  - Department Of Administrative Services (DOAS) – Medical Staff with faculty appointment for which the practitioner is paid by August University and insured by DOAS.
  - AU Medical Associates (AUMA) – Medical Staff who is employed by GRMA for which the practitioner is paid by GRMA are insured by GRMA.
  - Practitioners associated with neither Augusta University, AU Medical Center nor AUMA (Community Physicians) – The current insurance company must be financially sound and licensed in Georgia. Each practitioner is required to maintain such insurance and shall provide a certificate of insurance (which shall include agreement of the insurer to notify AU Medical Center in the event of cancellation).

• National Practitioner Data Bank/Healthcare Integrity and Protection Data Base are queried to determine (if applicable):
  - Medical malpractice payments.
  - Licensure disciplinary actions for all health related professions including those outside of medicine.
  - Adverse clinical privilege actions taken by a health care entity.
  - Adverse actions affecting professional society membership.
  - Adverse licensure and certification actions for all health related professions including those outside of medicine.
  - Exclusions from participation in federal and state healthcare programs.
  - Convictions and civil judgments related to healthcare.

• Medicaid/Medicare Sanctions are verified through the Internet by reviewing the Sanctions & Reinstatement Report through the Office of Inspector General (OIG) website. The OIG website is queried each month for Exclusions and Reinstatements, printed and kept in a binder in the Medical Staff Office. If a GRU practitioner is reported, the Chief Medical Officer and Clinical Service Chief are notified immediately. The South Carolina Excluded Practitioner list will also be queried. System for Award Management (SAM) and the Medicare Opt-Out for Georgia and South Carolina lists are also verified through the Internet by querying their website.
- Adverse findings: The Medical Staff Office notifies the Service Chief of any adverse findings that arise during the information gathering and verification process.
- The practitioner and Clinical Service Chief are notified by either in writing via email or by telephone that the re-appointment application is incomplete. They are told what is missing and the timeline to complete the process. If a medical or allied health staff member fails to submit an application for re-appointment by the end of their current appointment date, the member shall be deemed to have resigned their membership from the Medical Staff.

Responsibility of Service Chiefs: The Service Chief receives the completed application and supporting documentation from the Medical Staff Office. The Service Chief reviews the completed packet and makes a recommendation for reappointment and for renewing or revising clinical privileges. Criteria specified in the Bylaws constitute the basis for these actions and include evidence of current licensure, relevant training/experience, current competence (as determined by the results of quality assessment and performance improvement activities and peer recommendations), and ability to perform privileges requested (health status). The application is returned to the Medical Staff Office with a recommendation for reappointment and for renewed or revised clinical privileges if applicable. The Service Chief returns the endorsed application to the Medical Staff Office within seven (7) business days. If after seven (7) business days the Clinical Service Chief has not forwarded a recommendation on an application, the CMO and/or the President of the Medical Staff may forward the file to the Credentials Committee for action.

Responsibility of Credentials Committee: Members of the Credentials Committee review the completed, verified credentials file of each reappointed applicant and recommend to the Medical Executive Committee that the application be accepted, deferred, pended or rejected. In addition, an ongoing manner performance of the applicant related to their Ongoing Professional Practice Evaluation and/or Focused Professional Practice Evaluation be considered at the time of reappointment.

Responsibility of Executive Committee: The Medical Executive Committee reviews and accepts, rejects, defers or pends the recommendations of the Credentials Committee. The CMO then presents the Medical Executive Committee recommendations to the Board of Directors.

Responsibility of Governing Body: The Board of Directors makes the final decision to approve/disapprove all recommendations. This must occur within 180 days (6 mos.) of the signing of the application by the applicant. Only the Board of Directors has the authority to approve/disapprove a reappointment to the Medical and Allied Health Staff and/or to grant clinical privileges at AU Medical Center. Applications that are not acted upon by the Board within 180 days are deemed to have been withdrawn.
Fair-Hearing and Appeal Procedures: Whenever an adverse decision is made regarding an application for reappointment to the Medical or Allied Health Staff or renewing or revising clinical privileges, the fair hearing and appeal process outlined in Article VI of the Bylaws is described to the applicant. The National Practitioner Data Bank will be notified of any practitioner that meets reporting requirements as outlined in the NPDB guidelines.

Notifications: After approval by the Board of Directors the following are notified:
- The President/CEO and the President of the Medical Staff or their designee shall notify the applicant of his or her approval within 10 calendar days. An electronic notification goes out to all departments.
- The list of privileges is entered into the credentialing computer database to which the appropriate practice sites have immediate access to view.

Leave of Absence/Deployment
There are three options for practitioners on leave of absence or deployment at reappointment (medical, legal, personal or military obligations) whose reappointment/privileging is about to expire:

- Reappoint the practitioner prior to the start of the LOA.
- Allow the appointment to lapse and upon the practitioner’s return, implement the organizations process to grant temporary privileges until appointed again (in compliance with Bylaws).
- Reappoint the practitioner during the LOA based on information gathered to date, on the condition that the practitioner submits evidence of ability to perform the privileges granted or meet requirements on their return.

CHANGE OF PRIVILEGE REQUEST
Prior to reappointment, there may be a necessary and urgent need for a practitioner to request an increase to privileges, change of staff status or changes to privileges. In order to facilitate the management of privilege changes by the Clinical Service Chief and all appropriate committees, requests must be submitted in writing with appropriate documentation.

TEMPORARY CLINICAL PRIVILEGES
Overview and Process: Temporary privileges may be granted when a new applicant with a complete application, that raises no concerns, has been endorsed by the Credentials Committee and is awaiting review and approval of the Medical Executive Committee and Governing Body. Temporary privileges for new applicants are not to exceed 60 days. Temporary privileges are granted by the Credentials Committee Chair or authorized designee. The Medical Staff Office must receive a written request from the Clinical Service Chief requesting temporary privileges.
EMERGENCY TEMPORARY CLINICAL PRIVILEGES

An emergency temporary appointment will not be granted if one or more of the following has been identified during the application process:

- There is a current sanction or a previously successful sanction to licensure or registration.
- The applicant has received an involuntary termination of medical staff membership at another organization.
- The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges.

This process is in accordance to Article V, Section 5 of the Bylaws of the Medical Staff. When necessary to meet important patient care, treatment, and service need as determined by the Clinical Service Chief, the President/CMO with the concurrence of the President of the Medical Staff may grant emergency temporary clinical privileges to physicians only on a case-by-case basis. This requires the Clinical Service Chief to forward a memo to the Medical Staff Office requesting emergency temporary privileges. The memo must state the name of the physician needing emergency temporary privileges, reason immediate authorization to practice is required, privileges requested, patient’s name and date of procedure.

Emergency Temporary privileges are utilized in situations that include, but are not limited to, the following reasons:

- A specific licensed independent practitioner has the necessary skills to provide care to a patient that a practitioner currently privileged does not possess.
- The following information must be present prior to granting of emergency temporary privileges to fulfill an important patient care, treatment, and service need:
  - A completed application. If an error is made on any of the documents, the applicant is requested to strike the error with a single line and initial. White-out, correction tape or other means of correction products will not be accepted.
  - No current or previously successful sanction to licensure or registration
  - No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges
  - No subjection to involuntary termination of medical staff membership at another organization.
  - Current liability Insurance (in the amount of at least 1M/3M)
  - Current clinical competence (from a peer of the practitioner) that outlines relevant training or experience and ability to perform privileges requested. A peer evaluation will be available and must be completed.
  - A two year clinical history of procedures or activity log performed from their primary work site or a 2nd peer evaluation form (from a peer of the practitioner).
- Current Georgia medical license
- National Practitioner Data Bank (NPDB)
- Completed criminal background investigation form
- Current curriculum vitae
- Medicaid/Medicare Sanctions (OIG) for Georgia and Medicare Opt-Out in Georgia and South Carolina is queried
- System for Award Management (SAM) is queried

The Medical Staff Office upon receipt of the request for emergency temporary privileges will verify through primary source all items noted above.

**Member Complaints**

All member complaints are handled through the Quality Management Office.

**Quality Files**

Quality files are confidential and non-discoverable. They are maintained by the Quality Management Office and the Medical Staff Office has access to the files. Practitioners may have access to their own file upon request through either the Chief Medical Officer or the Director of Quality Management. The Quality Files will be a part of the reappointment process.

**Practitioner Review of Credentials Files**

A practitioner wishing to review his/her own file during the credentialing process is required to make an appointment with the Medical Staff Office; however, the Medical Staff Office will remove peer recommendation information prior to the review.

**Expiring Georgia State License/DEA**

The Medical Staff Office will maintain current state licensure on all practitioners by verifying with the Georgia Composite Medical Board, Georgia Board of Nursing or Georgia Board of Dentistry either verbally, in writing or via internet. Verification will be maintained in the file. If a practitioner has a current DEA, the Medical Staff Office will request a copy or will print a current copy from the internet for the file. The DEA will be verified through the National Technical Information Services (NTIS).

A list is generated each month with upcoming expiration dates for Georgia licenses and DEA expiration dates. If a Georgia license is not renewed and expires, the practitioner is immediately temporarily suspended until the practitioner has renewed the expired license. An electronic notification will be sent to the CMO, CNO, Clinical Service Chief, IT, HIM, Security and all others affected. Once the renewal process has been
completed, the temporary suspension will be lifted and everyone will be notified electronically.

The Georgia Composite Medical Board is queried each month to monitor sanctions against a practitioner’s license. If a practitioner has been sanctioned, an electronic notification will be sent to the CMO, CNO, Clinical Service Chief, IT, HIMS, Security and all other affected. The practitioner will be temporarily suspended until an investigation can be done. The temporary suspension will be lifted once the sanction has been lifted and an electronic notice will be sent to all involved.

**Name Changes**

The Medical Staff Office is responsible for updating the Credentialing database with name changes and forwarding name changes of credentialed practitioners to Health Information Management. No change will be made without the documentation of appropriate court documents.

**Sanction Reports through the Office of Inspector General (OIG)**

Each month the OIG exclusions and reinstatements along with Public Board Actions from the Georgia Composite Medical Board will be reviewed for practitioners credentialed through the Medical Staff Office. If a credentialed practitioner's name is found, the Medical Staff Office immediately notifies the Chief Medical Officer, Chief Nursing Officer, President of the Medical Staff, Legal and Risk Management. This information will be maintained in the Medical Staff Office.

**Tuberculin Skin Testing for Medical Staff**

Objective is to ensure that AU Medical Center medical and allied health staff are appropriately evaluated for latent TB infection (LTBI). This is to be done by periodic tuberculin skin testing (TST, also known as a PPD) or blood testing by QuantiFERON® TB or T-Spot®.

Documentation of tuberculin skin testing or interferon gamma release assay (QuantiFERON® or T-Spot®) within the past 12 months is required in order to have hospital privileges granted or renewed, unless there is a history of a prior positive TST. If tested positive, Positive PPD Reactions form should be completed.

**Telemedicine**

The Credentials Committee and Medical Executive Committee will recommend clinical services to provide telemedicine at AU Medical Center to the Board. AU Medical Center may act as either the distant site or the originating site.
**Disaster Privileging Plan for Licensed Independent Practitioners**

When the Emergency Operation Plan (EOP) has been activated for a local, state or national disaster, and the Chief Executive Officer or Chief Operating Officer has declared, in writing, that AU Medical Center is operating in a disaster mode (not emergency mode), disaster privileging can be authorized by the Chief Medical Officer or designees when the Children’s Hospital of Georgia and/or AU Medical Center is unable to handle the immediate patient care needs. Disaster privileges LIP’s and Non-LIP’s must be granted prior to providing patient care, even in a disaster situation, and decisions are made on a case-by-case basis at the discretion of the Chief Medical Officer. The practitioner will be assigned to an appropriate service on the AU Medical Center Medical Staff in which he/she is granted disaster privileges and the Clinical Service Chief or designee will be responsible for managing the activities of the practitioner. Disaster privileges do not confer any status on the medical or allied health staff to which the practitioner is assigned. The authorization to practice will be documented on the Disaster Privileging Plan Document.

**Contract for Delegated Managed Care Groups**

The policy to reflect the joint collaboration between the Medical Staff Office of AU Medical Center and the Managed Care Office of AU Medical Associates (AUMA) outlines the process about information submitted regarding specialty code and demographic information to delegated managed care companies.

The Provider Enrollment Department at AUMA is provided a list each month of new/reappointed/resigning providers. The Provider Enrollment Department will notify the managed care companies of any provider terminations, denials or resignations. This is not a delegated function for the Medical Staff Office.

**Responsibility**

The upkeep of this policy is the responsibility of the Chief Medical Officer and the Credentials Committees of the AU Medical Center.

**REFERENCES, SUPPORTING DOCUMENTS, AND TOOLS**

1. Change in Privilege form
2. Contract to delegate credentialing between AUMC and AUMA
3. Focused Professional Practice Evaluation (Policy ID: 159)
4. Ongoing Professional Practice Evaluation (Policy ID: 164)

**RELATED POLICIES**
https://paws.gru.edu/pub/medical-staff-office/Pages/default.aspx

APPROVED BY
Chief Executive Officer, AU Medical Center

Date: 09/06/2016