

DOH STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303

Troy, New York 12180-2299

Antonia C. Novello, M.D., M.P.H. Dr. P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

September 22, 2006

Dear Chief Executive Officer:

The Department recognizes that facilities expend considerable resources to carry out mandated credentialing activities. Facilities have over time sought to streamline these operations and implement efficiencies to the extent allowed under State Law and Department regulations. In response to questions raised and to address current practice patterns, this letter provides guidance to assist hospitals in fulfilling their obligations in the medical staff credentialing, appointment and reappointment process.

Sections 2805-j and 2805-k of the Public Health Law and the Department's implementing regulations define a facility's responsibility to maintain a coordinated program for practitioner credentialing prior to the granting of professional privileges.

The Department has become aware of various arrangements between New York hospitals and outside entities designed to assist and/or provide hospitals with credentialing services. When acting as an agent of the hospital, most types of businesses are not precluded by law from collecting and verifying information for credentialing purposes. While New York hospitals may contract with businesses or other Article 28 licensed hospitals to assist them in collecting and verifying relevant data, the governing body of the hospital must remain solely responsible for making final decisions regarding the granting of medical staff membership and professional privileges.

The attached "Question / Answer" (Q&A) document addresses many of the questions that have arisen in regard to carrying out hospital credentialing practices and in contracting for these services. The Q&A document is a working tool that will be posted and updated on the Health Provider Network (HPN) at <https://commerce.health.state.ny.us>. Should you have questions regarding any of the information provided or have additional questions/issues, please contact this office at (518) 402-1003, or send written correspondence to my attention at 433 River Street – 6th Floor, Troy, New York 12180.

Sincerely,



Martin J. Conroy
Director
Division of Primary & Acute Care Services



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Question / Answer Document Hospital Credentialing Practices

Legal / Regulatory

Q: What guidance has been issued by the Department in regard to hospital credentialing requirements?

A: With the enactment in 1985 of the Medical Malpractice Law, Department of Health Memorandums 86-7 and 86-106 set forth detailed explanations of the provisions of the legislation as well as the Department's implementing regulations at 10 NYCRR Section 405.4 (Medical Staff) and 405.6 (Quality Assurance Program). Federal requirements specific to medical staff privileging in the hospital Conditions of Participation provisions set forth in 42 CFR Part 482 outline a hospital privileging process that must be described in the hospital's medical staff bylaws and place ultimate responsibility with the hospital's governing body for the granting of professional privileges. State Education Law, Article 130 sets forth licensing requirements for physicians practicing in New York State and exemptions for physicians not licensed in this State to provide medical services in limited circumstances. In addition, the Department issued a "Dear Chief Executive Officer" letter on October 19, 1998 that provided guidance regarding contracts that could be entered into by hospitals to fulfill credentialing requirements.

Q: Can hospitals enter into contracts with outside business entities to carry out hospital credentialing practices?

A: A hospital may enter into a contract with an outside entity to carry out all or part of the professional application and verification process. This includes activities associated with the collection and verification of information specific to credentials and prior affiliations/employment. This does *not* include peer review and quality assurance activities and other performance improvement information used in the granting of professional privileges. A hospital may designate, by contract, an agent to receive and collect credentialing information, perform all required verification activities and act on behalf of the hospital for such credentialing purposes. Any such contract must establish that the hospital retains ultimate responsibility for the process required by Department regulations and its medical staff bylaws. The contract must state that the agent will abide by the confidentiality provisions of Section 2805-m of the Public Health Law. In addition, the contract must provide for the Department's access to any and all credentialing records of the credentialing agent. Hospitals may *not* delegate through a contract their responsibility for peer review, quality assurance/quality improvement activities and decision making authority for granting medical staff membership or professional privileges.

Q: How can hospitals that are affiliated share resources and information to reduce the paperwork burden associated with credentialing, peer review/quality improvement activities as well as the granting of professional privileges?

A: When multiple hospitals are operated by one corporation which has been established pursuant to Article 28 of the Public Health Law, known as an “active parent”, such corporation may carry out joint credentialing, peer review and quality assurance activities to the extent that such powers are specified in the provisions of the establishment authority and hospital bylaws.

Q: How can hospitals that are not affiliated share resources and information to reduce the paperwork burden associated with credentialing, peer review/quality improvement activities as well as the granting of professional privileges?

A: Hospitals that are not currently linked through an “active parent” may delegate to each other the authority and responsibility for the professional application and review process. This delegation must be accomplished through amendments to each hospital’s certificate of incorporation and bylaws to specify each hospital’s authority and responsibilities for the professional application and review process. Such cross delegation also requires approval of the State Public Health Council. Alternatively, a hospital can enter into a formal agreement with another entity or hospital to delegate the authority and responsibility for the professional application and review process. With either approach, each hospital must retain responsibility for making final decisions regarding the granting of professional privileges at its particular site.

Q: With joint credentialing practices there is a question of where records should be housed and who has ownership of the primary documentation?

A: If a contract to perform all or part of the professional application and verification process is in place, the terms of the contract must set forth where primary source documentation is maintained. Article 28 parent organizations usually retain flexibility to maintain records at a centralized location. However, the Department requires that each hospital granting professional privileges maintain a file for each practitioner. The file could include a summary report of the results of the credentials review and verification process. This could be a check list format agreed upon by the hospitals party to the centralized service. Documentation supporting the summary information must be available, accessible and retrievable, as needed, upon request by the Department.

Q: Is there a standard release form that hospitals should use to obtain practitioner consent prior to the sharing of information between facilities, affiliates, contracted credentialing agents, etc.?

A: A hospital is obligated to obtain a signed release from each practitioner that sufficiently addresses the conditions and terms for the release of information and provides for the confidentiality of information shared. Confidentiality concerns would be resolved through releases and waivers specifically authorizing a third party, i.e. credentialing agent, to receive and transmit the information obtained during the credentialing process. The Department does not endorse any specific or standard release form. Each hospital should consult with its legal counsel regarding the language in the release form to ensure it sufficiently addresses the conditions of release and confidentiality of information shared.

Q: May a hospital or a credentialing agent impose a fee for credentialing information when such information is requested by another hospital, health care facility, HMO, managed care organization, etc.?

A: Department regulations at 10NYCRR Section 405.6(b)(7)(iv) impose upon hospitals an obligation to provide to other hospitals specific information required to carry out the credentialing process. The law does not authorize a hospital or its agent to impose a fee on any other hospital or its agent as a prerequisite to furnishing information needed for credentialing purposes. In regard to credentialing information maintained by entities not licensed pursuant to Article 28 of the Public Health Law, the sharing of such information would be carried out in accordance with applicable terms of the contract.

Q: When verifying credentials, to what extent may hospitals rely on electronic verification?

A: Electronic verification of information available from the New York State Education Department (NYSED), the Federation of State Medical Boards/Federation Credentials Verification Service (FCVS) or the Educational Commission for Foreign Medical Graduates (ECFMG) may serve as primary source verification and obviates the facility's obligation to obtain/copy original documents.

Q: To what extent can a hospital rely on credentialing information collected/provided by a credentialing agent prior to the granting of professional privileges?

A: It is important that hospitals monitor the performance of contractor services and implement improvements and/or corrections as needed to assure quality outcomes. A hospital must hold the agent accountable for the quality of its work as specified in the terms and conditions of the signed contract. While a hospital may delegate by contract data collection tasks associated with the credentialing process, the hospital may not delegate its ultimate responsibility for the credentialing process. The hospital may not delegate by contract its role/responsibility for peer review and quality improvement activities. The hospital must retain its responsibility to fully review and consider the information collected and is solely responsible for making final decisions concerning the granting of medical staff membership and professional privileges.

Q: Over the course of ten years, some physicians have been affiliated with a significant number of facilities including possibly many out-of-state entities. Is it expected that all these sites will be identified and queried?

A: Department regulations at 10NYCRR Section 405.6(b)(7)(iii) impose an obligation on hospitals to request this information for at least the preceding ten years. The applying practitioner is expected to identify all contacts and the hospital or its credentialing agent must query all such contacts. While Article 28 providers within New York State are obligated to reply to such inquiries, out-of-state providers have no obligation to comply with any request for information. Hospitals are expected to query all reported contacts, and, in regard to out-of-state providers, expected to take reasonable steps to obtain a reply. The hospital is obligated to review and consider all information obtained through this process prior to granting membership or privileges but is not expected to persistently seek replies from sources that fail to reply and have no legal obligation to reply.

Granting of Professional Privileges

Q: There are times when physicians who are licensed in another state or jurisdiction seek to practice within New York State. What documentation must a hospital have prior to allowing such physicians to provide patient care services?

A: Education Law section 6526 sets forth the categories of physicians who are exempt from State licensure requirements. The State Hospital Code incorporates this section of law to allow physicians to practice within New York State without a New York State license. Specifically, Section 405.4(g) of 10 NYCRR addresses such physicians practicing under the authority of a limited permit and describes requirements for credentialing and the granting of professional privileges. Other categories of exempt physicians practice in accordance with the provisions in State Education Law and, as such, may travel to this state for a limited period to observe, consult or participate in patient care activities. For such physicians, hospitals must verify and document licensure in the physician's home state or jurisdiction. In addition, physicians consulting, practicing or providing patient care services at hospitals in New York State must meet appropriate immunization requirements. The scope and nature of the physician's visit must be documented, as well as any temporary privileges granted.

Q: In emergency situations, what is expected in terms of documentation prior to granting emergency privileges?

A: The Department has endorsed the JCAHO medical staff standards for granting disaster privileges when a hospital's emergency management plan has been activated. This standard allows the CEO or president of the medical staff to grant disaster privileges when they have been overwhelmed by an event. The standards rely on positive identification of the practitioner, a current license to practice, and identification that the individual is a member of a Disaster Medical Assistance Team (DMAT), prior to granting emergency privileges. The exempt provisions in State Education Law provide sufficient flexibility to allow practitioners licensed in other states and jurisdictions to practice on an emergency basis in New York State.

Q: Are physicians who are members of the United State Armed Forces and licensed in another state or jurisdiction authorized to provide professional services in Article 28 facilities?

A: Under Federal law at 10 USC section 1094, a health care professional who is a member of the armed forces who "(a) has a current license to practice medicine, osteopathic medicine, dentistry or another health profession; and (b) is performing authorized duties for the Department of Defense," is allowed to practice in a state in which s/he is not licensed. When practicing under these provisions, a physician's practice is limited to treating members of the armed forces or their dependents, and is a part of their military duties.

Telemedicine Privileges

Q: What are the licensing requirements for telemedicine providers?

A: Practitioners providing professional services in New York State must be licensed in this State. This includes physicians licensed in another jurisdiction who wish to practice medicine in

New York State. The practice of medicine is defined by Section 6521 of the Education Law: “as diagnosing, treating, operating or prescribing for any human disease, pain, injury, deformity or physical condition”.

Q: Prior to granting professional privileges, what credentialing requirements must be met for telemedicine providers?

A: Each hospital is responsible for assuring that all practitioners, including telemedicine providers, are fully credentialed prior to granting professional privileges. Hospitals may contract with outside entities to carry out the credentials review/verification process and the 10 year look back for prior affiliations and employment but must retain responsibility for making any final decision regarding the granting of professional privileges.

Q: What if the hospital contracts with a telemedicine group that will provide both professional services and carry out credentialing requirements?

A: The hospital may enter into a contract in accordance with the contract provisions set forth in Department regulations at 10 NYCRR Section 400.4. The hospital remains ultimately responsible for the contracted service. Such contracts do not need prior review by the Department but must be monitored by the hospital. The terms and conditions of such contracts must be clearly defined and each contract must preserve the hospital’s management authority and its rights and obligations.

The hospital may contract with outside entities for all or part of the professional application and credentials review/verification process as well as verification of prior affiliations/employment. The hospital may not delegate responsibilities specific to peer review, quality assurance/improvement activities and for making any final decision regarding the granting of professional privileges.

Q: If the telemedicine provider is JCAHO accredited, would the Department accept credentialing and privileging “by proxy” carried out by the JCAHO accredited telemedicine provider?

A: No. In meeting Department requirements, in accordance with State Law, hospitals may not delegate such responsibilities except by formal contract.

Q: In preparing the terms of a contract with a telemedicine group, what requirements must be met in regard to medical histories and physicals for telemedicine providers?

A: Telemedicine providers licensed in New York State but practicing from an out-of-state or out-of-country location must meet the general provisions for the history and physicals required by 10 NYCRR Section 405.3(b)(10).

Out-of-state telemedicine providers may request an exemption from infection control training due to the nature of their professional practice. A copy of the exemption request can be found on the Department’s web site at <http://www.health.ny.gov/qa/faq/telemedicine.htm> and once completed is submitted to the Department of Health for review/approval. Once

approved, the exemption approval may be submitted to the New York State Education Department at the time of license renewal.

Q: When entering into a contract with a telemedicine provider/group, what responsibilities must the hospital retain?

A: Hospitals assume ultimate responsibility for the quality of all patient care services and as such must carefully consider and monitor the terms and conditions of any such contract. Each hospital is responsible for making final decisions regarding the granting of professional privileges. Peer review and quality assurance/quality improvement activities shall not be delegated unless done through a legally established Article 28 parent corporation or through amendments to certificates of incorporation and by laws granting joint authority and responsibility for the professional application and professional review process. Each hospital must retain responsibility to comply with all reporting requirements set forth in 10 NYCRR Section 405.3.