

**STANFORD HOSPITAL AND CLINICS
LUCILE PACKARD CHILDREN'S HOSPITAL**

Credentialing and Privileges Department
Policy and Procedure Manual

VERIFICATION OF RENEWALS AND ADVERSE ACTION REPORTING

I. PURPOSE

To provide a mechanism to maintain current licensure and certification information for Medical Staff members, and to deal with adverse actions against these licenses and certificates.

II. POLICY

Medical Staff Services will be responsible for keeping documents of professional licenses, certificates, insurance and malpractice current in the providers' credentials files, and the Chief of Staff and President and CEO of hospital shall be responsible for reporting adverse actions to the appropriate regulatory agencies as required by law.

III. PROCEDURE

Expiring licenses and/or certificates

Each month, an audit will be done of the database to determine which providers have a California Professional License, DEA Certificate, or Fluoroscopy Certificate (X-Ray Supervisor & Operator) that will be expiring at the end of that month.

Verification of renewal of licensure is obtained by querying the Medical Board of California (online or by phone), or by requesting a current copy from the provider. Verification of current DEA Certificate will be obtained direct from the National Technical Information Service (NTIS on-line verification) of the U.S. Department of Commerce, or by requesting a current copy from the provider. Copies of current Fluoroscopy Certificates must be requested from the provider.

If this documentation is not received one week before expiration, a follow-up call is placed to the provider. If the provider fails to respond, the Chief of Staff and appropriate Service Chief are notified and the following steps are taken:

1. Expired California Professional License

The provider is automatically suspended from practice at midnight on the day of expiration until there is evidence of a licensure renewal. A certified notice is sent to the provider indicating membership suspension. The credentialing database is updated and provider delineation of privileges are eliminated to reflect these suspensions. The provider is removed from suspension once the licensure has been renewed.

2. Expired DEA Certificate

A listing of providers with expired DEA Certificates is forwarded to the SHC and/or LPCH Pharmacy each month. The provider's right to prescribe, dispense, or administer medications covered by the certificate is automatically suspended until there is evidence of a certificate renewal. The listing is updated as certificates are renewed and/or on a monthly

basis.

3. *Expired Fluoroscopy Certificate*

A listing of providers with expired Fluoroscopy certificates is forwarded to Radiology and the Operating Room each month. The provider's right to directly control radiation exposure to patients, supervise persons who hold radiologic technologist fluoroscopy permits or to actuate or energize equipment covered by the certificate is automatically suspended until there is evidence of a certificate renewal. This listing is updated as certificates are renewed.

4. *Expired Board Certification*

A listing of providers with expired Board Certification will be sent to their respective Service Chiefs for review. Health Plans also require a copy of anyone with an expired Board Certification.

5. *Expired Insurance*

A listing of providers with expired Insurance will automatically be suspended from practice at midnight on the day of expiration until there is evidence of insurance renewal. A certified notice is sent to the provider indicating membership suspension. The credentialing database is updated and provider delineation of privileges are eliminated to reflect these suspensions. The provider is removed from suspension once the licensure has been renewed.

IV. Adverse Actions

A. Medicare/Medicaid Sanctions: OIG Exclusions

Upon initial appointment and reappointment and monthly OIG reports, a query will be performed to view any OIG exclusions. On-line verification from the HHS Office of Inspector General official exclusions program will take place for each medical staff member who have clinical privileges. The OIG exclusion program identifies all individuals and entities that have been prevented to participate in federally funded health care programs. Copies of the verification obtained from the OIG Exclusion program will be stored in each provider credentials file. Any exclusions found will be forwarded to the associated department, Credentials Committee and the Finance Department for review.

OIG Monthly exclusion reports are reviewed on monthly basis or within 30 days of release.

B. Hot Sheet – Monthly Disciplinary Summary from Medical Board of California

The Medical Board of California Disciplinary Summary Report and the Osteopathic Medical Board of California Enforcement Actions is reviewed each month in the Credentialing Office. The names on the report are reviewed to determine if any of them are currently on the Medical Staff at Stanford Hospital and Clinics or Lucile Packard Children's Hospital. If it is determined that a current member of the Medical Staff has had an action filed against his/her license, the Credentialing Office will contact the Medical Board of California for documentation of the action. In addition the provider will be asked for documentation. This documentation will become part of the provider's credentials file and will be forwarded to the Hospital Credentials Committee, Legal Counsel and the Chief of Staff for review and determination if any action needs to be taken on the part of Stanford Hospital and Clinics or Lucile Packard Children's Hospital. If license is suspended/revoked the provider will immediately be inactivated until further information is gathered.

The Medical Board of California “Hot Sheet – A Disciplinary Summary” report is a monthly summary of disciplinary matters for the Medical Board of California and the following boards and committee:

- Physical Therapy Board of California
- Physician Assistant Committee
- Board of Podiatric Medicine
- Board of Psychology

Disciplinary Summary on licensure from the Dental Board of California is reviewed separately by two methods 1) review of practitioners license verification from Dental Board of California and 2) notices received from Dental Board of disciplinary actions against licensure.

Hot Sheet reports are reviewed by the Credential Committee on a monthly basis or within 30 days of release.

C. Filing an 805 report with the Medical Board of California

The Chief of Staff and the President and CEO of Stanford Hospital and Clinics and Lucile Packard Children’s Hospital are responsible for reporting certain actions with respect to medical staff membership and clinical privileges of physicians, podiatrists and psychologists to the Medical Board of California on a Health Facility Reporting Form (805 Report). Reports on osteopathic physicians and dentists would be directed to their respective Boards. The reports must be filed when the actions are imposed or voluntarily accepted for a “medical disciplinary cause or reason” which means that aspect of the provider’s competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

D. Filing a report with the National Practitioner Data Bank

The Chief of Staff and the President and CEO of Stanford Hospital and Clinics and Lucile Packard Children’s Hospital are responsible for reporting certain actions with respect to medical staff membership and clinical privileges of physicians, dentists, and other health care practitioners to the National Practitioner Data Bank on an Adverse Action Report Form. Reportable actions include:

- professional review action, based on reasons related to professional competence or conduct, adversely affecting clinical privileges for a period of longer than 30 days
- voluntary surrender or restriction of clinical privileges while under, or to avoid, investigation for possible professional incompetence or improper professional conduct or in return for not conducting an investigation or professional review action
- adverse actions including reducing, restricting, suspending, revoking, or denying privileges, or a decision not to renew privileges, if that action or decision was based on the practitioner’s professional competence or conduct
- voluntary withdrawal of an initial application for medical staff membership and/or clinical privileges while provider under investigation by the hospital for possible professional incompetence or improper professional conduct **or** in return for not conducting such an investigation or taking a professional review action
- summary suspension if in effect for more than 30 days, based on professional competence or professional conduct that could affect the welfare of a patient, or as a result of a professional review action taken by the hospital

Section 805 and reports to the National Practitioner Data Bank will be filed in accordance with the Medical Staff Bylaws, and within the time and in a manner required under federal and state statutes and regulations.

E. Background Checks

Background checks are processed for all new applicants and for all reappointments. Any information received on these reports is flagged for special review by the Service Chief and the Credentials Committee(s). If information is received regarding a past DUI conviction or guilty plea, the provider is sent a letter requiring that he/she contact the Chair of the Well-Being Committee (WBC) to discuss the issue. The Chair will report back to the Well-Being Committee on all such interviews and a determination will be made by the WBC as to whether or not further monitoring is recommended. Failure on the part of the provider to schedule the meeting with the Chair of the WBC will deem the application packet incomplete.

IV. RELATED DOCUMENTS

-- Stanford Hospital and Clinics Medical Staff Bylaws, Rules and Regulations

V. DOCUMENT INFORMATION

A. Legal Authority/References

None

B. Author/Original Date

This Policy was authored by the Director, Medical Staff Services in April, 2000.

C. Gatekeeper of Original Document

The Director of Medical Staff Services (or designee), who will be responsible for initiating its review and revision. The Policy will reside in the Credentials Policy and Procedure Manual, a copy of which is kept in the Medical Staff Office.

D. Distribution and Training Requirements

The distribution and training requirements for this Policy will be handled through the Credentials Department.

E. Requirements For Review and Renewal

This Policy will be reviewed and/or revised every three years or as required by change of law or practice.

F. Review and Revision History

4/01, 9/02, 9/03, 1/08

G. Local Approvals

Legal Review – June, 2000

Credentials Committee – June 2000, 4/01, 9/02, 9/03, 3/04, 6/05, 1/08

Medical Executive Committee 2/08

Well-Being Committee – January, 2004

H. Board Approvals

July 2000, 5/02, 10/03, 7/05, 2/08

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