UNIVERSITY OF MARYLAND MEDICAL CENTER

CREDENTIALING PROCEDURES MANUAL

PART ONE: INITIAL APPOINTMENT PROCEDURES

1.1 Initiation of Application Process

As a part of the recruitment process, each clinical department is responsible for notifying Medical Staff Services that an applicant has been selected. The department credentialing representative indicates the clinical service and division in which the applicant will be credentialed, the anticipated start date, percentage of clinical activity at UMMC and affiliation with other University of Maryland Medical System Hospitals on the Attending/Affiliate Application Request Form. Medical Staff Services will then be responsible for providing the applicant with a link to the UMMC Medical Staff Services website. The provider may download the following materials:

(a) Application for medical staff appointment;

(b) Delineation of Privileges form;

(c) A copy of the Medical Staff Bylaws and Credentialing Procedures Manual.

(d) Code of Professional Conduct

(e) Required online training materials

(f) Health Assessment Documents

1.2 Application and Additional Required Materials

An application for medical staff appointment must be submitted by the applicant in writing and on the form recommended by the Credentials and Medical Executive Committees and approved by the Board of Directors. Effective March 2004, the Maryland State Hospital Credentialing Application will be used for all initial appointments. An addendum with hospital-specific information will also be collected from the applicant. In addition to the application, the applicant is required to provide the following:

(a) Up-to-date Curriculum Vitae indicating month/year of all affiliations;

(b) Delineation of Privileges form;

(c) University of Maryland Medical System Consent to Release Information form;

(d) Proof of current Maryland license;

(e) Proof of current Federal Drug Enforcement Agency (DEA) registration indicating a Maryland address; (if applicable) or submission of the UMMC Controlled Substance Prescribing Status form (CDS Attestation form); The Medical Staff Services Department will utilize the form for all new applicants to acknowledge their prescribing status and intentions to prescribe at the University of Maryland Medical Center. The form will be signed by applicants who either do not prescribe controlled substances or whose Maryland CDS and/or Federal DEA registrations are pending at the time of initial appointment. The form may also be used at reappointment and in the case of non-renewal of Maryland CDS or Federal DEA registration.

(f) Proof of current Maryland Controlled Dangerous Substances (CDS) registration; (if applicable) or submission of the UMMC Controlled Substances Prescribing Status form (CDS Attestation form) see above;

(g) Proof of Board certification, if applicable;

(h) Proof of current malpractice insurance coverage in the amount of $1,000,000 per occurrence and $3,000,000 aggregate as required by the Board of Directors or completion of the Maryland Medicine Comprehensive Insurance Program portion of the credentialing application addendum.

(i) Code of Professional Conduct attestation

(j) Current BCLS, ACLS, PALS or applicable life support certification (if applicable)

(k) Written explanation of any gaps in professional career/clinical activity greater than three (3) months which occur after graduation from professional degree until the time of application

(l) Written explanation of all malpractice actions regardless of payment made on behalf of the applicant

1.3 Application Content

Every applicant must furnish complete information concerning at least the following:

(a) Citizenship;

(b) Undergraduate, professional school, and postgraduate training;

(c) All past and all currently valid medical, dental, podiatric, psychology, advance practice nursing, physician assistant and other professional licenses or certificates, Federal Drug Enforcement Administration (DEA), and any other controlled substance registration;

(d) Status of specialty and subspecialty board certification.

(e) Any previous or current physical/mental condition (including alcohol or drug dependence) that limits or adversely affects the applicant's to participate fully in the care of his patients. In addition, any information regarding hospitalization, institutionalization or involvement in a patient treatment program that limited the applicant’s ability to participate fully in the care of his patients.

(f) Current malpractice insurance certificate issued to UMMC. Evidence of continuous medical malpractice coverage and information on malpractice claims history in the past 5 years and experience (suits and settlements made, concluded, and pending), including the names and addresses of present and past professional liability insurance carriers;

(g) Compliance with continuing medical education requirements as set forth by the licensing board for licensure, documented by attestation on application;

(h) Any pending or completed action involving denial, revocation, suspension, reduction, limitation, probation, or voluntary or involuntary surrender of any of the following:

(i) license or certificate to practice any profession in any state or country;

(ii) Federal Drug Enforcement Administration (DEA) or other state controlled substance registration;

(iii) membership or fellowship in local, state or national health or scientific professional organizations;

(iv) faculty membership in any medical or other professional school;

(v) appointment or employment status, prerogatives or clinical privileges at any other hospital, clinic or health care institution or organization;

(vi) participation in managed care organizations;

(vii) professional liability insurance;

(i) Any pending or completed complaint or report filed with any State of Maryland licensing Board, state medical society or professional association;

(j) Any instances of non-renewal, relinquishment (by resignation or expiration), limitation, or withdrawal of staff membership or clinical privileges or failure to proceed with an application for any of the items listed in (h) above in order to foreclose or terminate actual or possible investigation or disciplinary or adverse action;

(k) Department and staff category for which privileges are requested;

(l) Location of offices; names and locations of all other hospitals, clinics, or health care institutions or organizations where or through which the applicant provides or has provided clinical services with the inclusive dates of each affiliation, status held, and general scope of clinical privileges.

(m) Any prior or current criminal charges including their resolutions that include but are not limited to those related to motor vehicle violations, drug or alcohol related offenses, sexual misconduct and/or sexual harassment or harassment on the basis of race, creed, color, religion or sexual orientation.

(n) Evidence of the applicant's agreement with the authorization, confidentiality, immunity, and release provisions of the Medical Staff Bylaws and the Credentialing Procedures Manual;

(o) Complete information regarding professional activities since entrance into medical/dental/professional school with a written explanation provided for any time gaps greater than three months;

(p) Exclusion as a provider from any governmental insurance program (e.g. Medicare, Medicaid) or any other governmental program.

(q) The names of at least two (2) peer references who Medical Staff Services may contact to submit a confidential evaluation to support the applicant’s credentialing application.

(r) Current Photo

(s) Current PPD Skin Testing results (within 1 year)

(t) Copy of a Federal or State Issued Identification (driver’s license or passport)

1.4 Conditions of Application

The applicant must provide an original signature on application materials. Signature stamps are not permitted. In so doing, the applicant:

(a) Agrees to abide by the terms of the Bylaws and related manuals, rules, policies and procedures of the Medical/Affiliate Staff and those of the Medical System if granted appointment and/or clinical privileges, and to abide by the terms thereof in all matters relating to consideration of the application without regard to whether or not appointment and/or privileges are granted;

(b) Agrees to report immediately to the Medical System any occurrences, incidents, actions or other information relating to questions in this application, if such occur following the filing of this application or its acceptance;

(c) Signifies willingness to appear for interviews in connection with the application;

(d) Attests to the correctness and completeness of all information furnished to the best of his/her knowledge and belief and acknowledges that any material misstatement in or omission from the application constitutes grounds for denial of appointment or for summary dismissal from the staff without recourse to the procedural rights provided in Article IX of the Medical Staff Bylaws;

(e) Agrees to maintain an ethical practice and to provide or arrange for continuous care for all patients under his/her care and to perform only that medical and surgical management for which the applicant has been granted privileges, or which he/she is permitted by the Medical Staff Bylaws to perform in order to save the life of a patient in an emergency situation or to save a patient from serious harm. The applicant understands that if the application is rejected, he/she shall have no privileges whatsoever at the Medical System or only those privileges eventually approved by the Governing Board of the Medical System;

(f) Agrees to immediately notify the Medical Staff President and the Chief Executive Officer of any change made or formal action initiated that could result in a change in the status of his professional license to practice, DEA or other controlled substances registration, professional liability insurance coverage, and appointment or employment status at, affiliation with, or clinical privileges at other institutions or organizations, and on the status of current or initiation of new malpractice claims;

(g) Agrees to immediately notify the Medical Staff President and the Chief Executive Officer of any change in his/her health status that could adversely affect his/her ability to practice as delineated.

(h) Authorizes and consents to hospital representatives consulting with prior associates or others who may have information bearing on professional or ethical qualifications and competence and consents to their inspecting all records and documents that may be material to evaluation of said qualifications and competence and understands that requests may be made of past or present medical affiliates, professional societies, licensing bodies, and other agencies regarding criminal history information;

(i) Releases from any liability all those who, in good faith and without malice, review, act on or provide information regarding the applicant's background, experience, clinical competence, professional ethics, utilization practice patterns, character, health status, and other qualifications for staff appointment and clinical privileges.

(j) Understands that as a member of the Medical/Affiliate Staff, he/she is participating with the Medical Center in an organized health care arrangement as defined by the Privacy Regulations under HIPAA. He/she agrees to comply with policies on protected health information and its notice of information of privacy practices with regard to Medical Center patients.

1.5 Application Process

1.5.1 Applicant's Responsibility

The applicant has the burden of producing adequate information for a proper evaluation of his experience, training, current competence, clinical skills, utilization practice patterns, ability to work cooperatively with others, health status, and of resolving any doubts about these or any of the qualifications required for staff appointment or the requested staff category, department assignment, or clinical privileges, and of satisfying any requests for information or clarification (including health examinations) made by appropriate Medical Staff or Board authorities.

During the appointment and reappointment process, the applicant retains the right to

(a) Review and correct any errors in information provided to Medical Staff Services with regard to his/her application.

(b) Be informed of the status of his/her application/reappointment application.
1) Upon request for status of application the Medical Staff Services representative will communicate to the applicant via email, telephone, or written letter based on the applicants preferred method of contact. Within that communication the representative will confirm complete or incomplete application. In the case of an incomplete application the applicant will be told what is required to complete the application. The applicant will not be given access to any peer-review protected information.

(c) Review/amend the application for completeness, accuracy and to clarify conflicting information prior to submission through the approval process.

(d) Within 30 days of receipt of a completed application, Medical Staff Services will notify the applicant in writing of the application's receipt and request any additional items needed to complete the application materials.

1.5.2 Verification of Information

The applicant shall submit the completed applications and other required materials to Medical Staff Services. Representatives of Medical Staff Services, working with the departmental credentialing representative and the Credentials Committee, organize and coordinate the collection and verification of education, training, prior and current affiliations, peer references, licensure and other information submitted. The Medical Staff Coordinator will promptly notify the applicant of any missing information within or problems obtaining the information required. The Medical Staff Coordinator will request the applicant provide responses to the requested information in writing within 10 business days. Documentation of said responses will be recorded and filed in the credentials file. This notification must indicate the nature of the information the applicant is to provide and the time frame for response. Failure, without good cause, to respond in a satisfactory manner by the date indicated is deemed a voluntary withdrawal of the application.

Verification shall include, without limitation primary source confirmation of:

(a) Medical, Dental, Podiatric, Psychology, Advanced Practice Nursing or other Professional education (via National Student Clearinghouse (www.degreechk.com);

(b) Internship, residency and fellowship training (via AMA Profile Service, written letter to institutions or hospital website as available);

(c) Prior and Current hospital affiliations (via written letter to institutions or hospital website as available);

(d) State licensure for all states in which the provider is/has been licensed (via online state license verification websites);

(e) State Controlled Dangerous Substances (CDS) registration and DEA (Federal DEA & state CDS licenses are verified via copy of the license);

(f) Current and prior malpractice insurance and explanation of all prior malpractice claims;

(g) Board certification (verified via Certifacts (www.certifacts.org) or (www.doprofiles.org) or websites of other certification agencies as necessary);

(h) ECFMG certification (if applicable) (www.ecfmg.org) ;

(i) Current faculty appointment with the University of Maryland School of Medicine or Dentistry as applicable;

Two requests to verify this information shall be made by Medical Staff Services. At this point, the applicant will be notified to contact the source directly. In the case of foreign institutions, if Medical Staff Services is unable to obtain verification after two requests, the applicant will be asked to present notarized copies of applicable documents to Medical Staff Services.;

(j) Receipt of a confidential evaluation form from training programs, prior and current affiliations which includes specific information and ratings, as appropriate, on all aspects of the applicant's performance at that institution which may bear on his qualifications for staff

appointment or the privileges requested. These include but are not limited to, ability to work with others, clinical competence, medical record documentation, participation in staff activities, and availability for patient care;

(k) Receipt of two (2) peer evaluations, a minimum of one being from someone of the same professional discipline. Evaluations accepted shall include assessment of medical/clinical knowledge, technical and clinical skills, clinical judgement, interpersonal and communication skills, and professionalism.

New Nurse Practitioner Graduates or First Time APRNs: At least one reference from a faculty member from Nursing School is required; CRNA Applicants: At least one reference from a physician is required.

(l) Submittal of the list of clinical privileges requested by the applicant at the Medical Center to at least the applicant's most recent affiliations along with a request for specific information regarding the applicant's experience and competence in exercising each of the privileges requested;

(m) Requests for reports from the National Practitioner Data Bank, American Medical Association via AMA Profile Service (https://profiles.ama-assn.org/amaprofiles/)

(n) Criminal history background search via First Advantage (www.cpscreen.com) or via Hire Right for criminal history background searches provided by HR for Allied Health Practitioners;

(o) Medicare/Medicaid Sanction via Compliance Concepts, Inc (www.sanctioncheck.com);

(p) Five-year claims history;

(q) Review of Medicare Opt-Out Provider data (via www.trailblazerhealth.com/tools/opt-out.asp)

During the credentialing process, the Medical Staff Coordinator will contact the applicant in writing to discuss any variances from the information provided on the credentialing application. Medical Staff Services will allow correction of said information, as outlined in Section 1.5.1 via a letter from the applicant or addendum to the original application. This policy applies to both initial appointment and reappointment of medical staff membership and clinical privileges.

1.5.3 Responsibilities of Department and Evaluation by Chairman

The Chairman of the Department in which privileges are requested reviews the completed application, supporting documents submitted by the practitioner and all primary source documents received by Medical Staff Services. The Chairman shall evaluate the applicant's qualifications for staff membership and for delineation of clinical privileges on the Service in accordance with the following criteria:

(a) licensure status;

(b) specialty board certification status (if applicable);

(c) relevant training and experience;

(d) compliance with continuing education requirements,

(e) ability to perform professional duties;

(f) past professional performance and current competence;

(g) peer evaluations;

(h) malpractice claims history;

The Chairman shall submit his recommendation to either grant or to deny clinical privileges and Medical/Affiliate Staff membership, either initial appointment or reappointment, based upon the above-enumerated criteria and any service-specific criteria. If a recommendation is for rejection of the application or for denial of clinical privileges or denial of service affiliation requested by the applicant, the report and recommendation of the Chairman shall include specific written justification for the recommendation.

A separate review and approval will be requested of the Chairman by Medical Staff Services when an evaluator provides negative comments about professional performance and/or competence. Multiple claims or those with excessive settlements will be forwarded to the Maryland Medicine Comprehensive Insurance Program for review and evaluation.

As stated in Article 12 of the Medical Staff Bylaws, the applicant may retain the right to a formal hearing as a result of an adverse action by the Credentials Committee, Medical Executive Committee or Board of Directors.

1.5.4 Credentials Committee Evaluation

The Credentials Committee is comprised of representatives of all clinical departments both physicians, dentists, psychiatrists and advanced practice nurses. The members agree to perform the functions of reviewing credentialing materials and supporting documentation in a non-discriminatory manner. All members are required to sign a written attestation that their decision making process will not be performed in a discriminatory manner.

To ensure the credentialing process takes place in a non-discriminatory manner, on a quarterly basis, the Manager, Credentialing Compliance reviews any denials to identify any trends related to discriminatory practices. If such practices are found, information will be forwarded to the Credentials Committee Chair for further action and process change, if necessary.

The Credentials Committee shall review the application, supporting documentation, recommendations from the Chairman and any other relevant information available to it for all initial appointment and reappointment applications. The Credentials Committee may conduct an interview with the applicant or designate one or more of its members to do so. If the Credentials Committee requires further information, it may defer transmitting its report to the Medical Executive Committee but generally for not more than thirty (30) days, except for good cause. If the applicant is to provide additional information, a request is to be made for the specific information needed and the time for response. Failure, without good cause, to respond in a satisfactory manner by that date is deemed a voluntary withdrawal of the application. The Credentials Committee shall prepare its written report and recommendations and present it to the Medical Executive Committee.

(a) Ad-Hoc Committee Approval of Credentials

To approve credentials of new providers who have not received their Maryland medical license, the Credentials Committee will convene a 3 member panel outside of the regularly scheduled meeting. This meeting will be held after the regularly scheduled meeting but before the Board of Directors approval. All credentials will be reviewed and a written report will be forwarded to the Medical Executive Committee to be presented at the next regularly scheduled meeting. The Ad-Hoc Committee meeting will be utilized during the months of June and July only in order to approve newly hired attending faculty. Physicians whose Maryland medical license has not been approved by the Credentials Committee date are not permitted to be approved per NCQA guidelines. UMMC Medical Staff Services must abide by these standards per delegated credentialing contracts.

1.5.5 Action by the Medical Executive Committee

The Medical Executive Committee (MEC) shall, at its next regular meeting after receiving the report of the Credentials Committee, review it as well as the reports and recommendations from the Chairman and any other relevant information made available to or requested by it. The MEC may, at its discretion, conduct an interview with the applicant or designate one or more of its members to do so. The Medical Executive Committee may defer action on the application or prepare a written report with recommendations.

1.5.6 Effect of Medical Executive Committee Action

(a) Deferral: Action by the Medical Executive Committee (MEC) to defer the application for further consideration must, except for good cause, be followed up within thirty (30) days with a report and recommendation. The President of the Medical Staff shall promptly send the applicant, through Medical Staff Services, a request for specific information needed, if any, required from the applicant and the time frame for response. Failure, without good cause, to respond in a satisfactory manner by the date indicated is deemed a voluntary withdrawal of the application.

(b) Favorable Recommendation: An MEC recommendation that is favorable to the applicant in all respects is forwarded, together with written recommendation from the Medical Executive Committee, The Patient Quality and Safety Committee of the Board of Directors or appropriate Committee thereof.

(c) Adverse Recommendation: An adverse Medical Executive Committee recommendation is forwarded to the Chief Executive Officer who shall inform the applicant as provided in the Medical Staff Bylaws, and the applicant is then entitled, upon proper and timely request, to the procedural rights as provided in the Medical Staff Bylaws.

1.5.7 Action on the Application

As part of any of its actions outlined below, the Patient Quality and Safety Committee of the Board of the Board of Directors may, at its discretion, conduct an interview with the applicant or designate one or more individuals to do so on its behalf. If, as part of its deliberations, the Board determines that it requires further information, it may defer action but generally for not more than sixty (60) days except for good cause, and it shall notify the applicant, the President of the Medical Staff, and the Chairman in writing of the deferral and the grounds. If the applicant is to provide additional information, the notice to him/her must so state, and must include a request for the specific information needed and the time frame for response. Failure, without good cause, to respond in a satisfactory manner by that date is deemed a voluntary withdrawal of the application. The Governing Body may accept the recommendation of the Medical Executive Committee or may refer the matter back to the Medical Executive Committee for further consideration, stating the purpose for such referral. The decision of the Governing Body shall be final subject to the procedural rights under Article 12.

1.5.8 Content of Report and Basis for Recommendation and Action

Each individual or group providing a recommendation or acting on an application shall have available the full resources of the Medical Staff and the Medical System as well as the authority to use outside consultants as deemed necessary. The report of each individual or group required to act on an application must include recommendations as to approval or denial of, and any special limitations on staff appointment, category of staff appointment, department and division affiliation, and scope of clinical privileges. All documentation and information received by an individual or group, during or as part of the evaluation process must be included with the application as part of the individual's credentials file and, as appropriate or requested, transmitted with reports and recommendations. The reasons for each recommendation or action to deny, restrict or otherwise limit must be stated, with reference to the completed application and all other documentation considered. Any dissenting views from the majority position at any point in the process must also be documented including the reason for the differing view and the information on which it is based and the alternative recommendation, if any. This minority position must be transmitted with the majority report.

1.5.9 Notice of Final Decision

(a) The Chief Executive Officer shall give notice of the final decision in writing to the applicant and to the Medical Staff President, and to the applicable Chairman;

(b) The decision and notice to appoint includes:

(i) the staff category to which the applicant is appointed;

(ii) the service to which the applicant is assigned;

(iii) the clinical privileges the applicant may exercise;

(iv) any special conditions attached to the appointment; and

(v) period of appointment (not to exceed two years).

(c) The Medical Staff Office will issue a letter within 30 days notifying each approved practitioner of their credentialing decision, indicating initial and/or reappointment effective date and anticipated date of next evaluation.

1.5.10 Time Periods For Processing

All individuals and groups required to act on a completed application for staff appointment or reappointment must do so in a timely and good faith manner. Except for obtaining required additional information or for other good cause, the gathering and verification of information by Medical Staff Services shall not exceed 180 days from the date of attestation signature to presentation to the Credentials Committee. The application is to be reviewed by the Credentials Committee at the next regular meeting after receiving the file from Medical Staff Services. The application is then to be reviewed at the next regular meeting of the Medical Executive Committee after recommendation from the Credentials Committee. The application is then to be reviewed at the next regular meeting of the Patient Quality and Safety Committee of the Board of Directors after receiving the recommendation from the Medical Executive Committee.

These time periods are to be deemed guidelines and are not directives and do not create any rights for a practitioner to have an application processed within these precise periods.

If the Credentials Committee has been not acted upon an application within the 180-day State of Maryland regulation, the application will be considered expired. A new application, signed Consent to Release Information form and Delineation of Privileges form will be required to resume processing the application for approval. Medical Staff Services will re-verify all applicable primary source items in accordance with JCAHO and NCQA regulations.

1.6 Initial Professional Practice Evaluation

Initial professional practice evaluation is defined as a time-limited period during which the organization evaluates and determines a practitioner's professional performance of privileges. This will occur in all requests for new privileges by assessing for proficiency in the areas of general competencies for patient care, medical and clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice.

Information for this evaluation may be derived from the following:

(a) Chart review
(b) Practitioner Profile review
(c) Proctoring
(d) Simulation

(e) Discussion with other individuals involved in care of each patient
(f) External peer review, if necessary

The Service or Section Chief shall be responsible for overseeing the evaluation process for all applicants or staff members assigned to their division. Medical Staff Services will be responsible for monitoring compliance with this requirement and will assist in obtaining documentation.

1.6.1 The type of evaluation to be used will be determined by the Service or Section Chief based on the individual practitioner's circumstance using the following guidelines:

(a) Peer recommendations from previous institutions will be reviewed by the Service/Section Chief;
(b) Performance indicators on the practitioner profile will be monitored;
(c) Procedure/clinical activity logs may be requested from previous institutions or training programs and reviewed;
(d) A peer evaluation from the Service or Section Chief will be completed.

1.6.2 The initial evaluation shall begin with the applicant's first admission or performance of the newly requested privileges. Each department will determine the number of cases or charts to be reviewed. . The evaluation should be completed by 3 months; however, for infrequently used privileges, this period may be extended.

1.6.3 If proctoring is required, the proctor must be in good standing of the active medical staff of UMMC and have unrestricted privileges to perform any procedure to be observed. The proctor should be mutually agreed upon between the Department Chair or Section Chief and the practitioner being proctored.

PART TWO: REAPPOINTMENT PROCEDURES

2.1 Reappointment Cycle

Reappointment to the Medical or Affiliate Staff must be completed every two years after the initial appointment date. An UMMC-specific reappointment application will be sent to each provider in advance of his or her reappointment date.

2.2 Information Collection and Verification

2.2.1 From Staff Member

On or before six months prior to the date of expiration of a medical staff member's appointment, not to exceed two years from the date of appointment, Medical Staff Services shall notify the member of the date of expiration and forward an application for reappointment to be completed.

At least one hundred twenty (120) days prior to the expiration date, the member shall furnish, in writing on the application for reappointment:

(a) complete information and all documents necessary to bring the file current on the items listed in Section 1.3, including current license and DEA registration, CDS registration**,** professional liability insurance coverage and malpractice claim experience since the last reappointment cycle, other institutional affiliations and status thereof, board certification status, disciplinary actions pending or finalized, ability to perform professional duties;

(b) continuing medical education (CME) and/or training during the preceding period documented by attestation on application;

(c) specific request for the clinical privileges requested for the next appointment period, with any basis for changes from those currently held;

(d) requests for changes in staff category or department assignments. The staff member must sign the reappointment application and in so doing accepts the same conditions as stated in Section 1.4 in connection with the initial application;

(e) signed attestation and Consent to Release Information form;

(f) physicians, dentists, podiatrists and clinical psychologists with low or no activity at UMMC must provide performance data within the last 2 years from their primary hospital.

If the staff member has not returned his completed application for reappointment or requested an extension by the one hundred twentieth (120) day prior to the expiration date, Medical Staff Services shall send notice to the medical staff member that the reappointment application has not been received and that the staff member has a ten (10) day grace period in which to submit the application or request for extension. Failure, without good cause, to provide the fully completed reappointment application with all required information prior to or within the grace period is deemed a voluntary resignation from the staff, and the staff member's appointment will not be renewed for the following term. A practitioner whose appointment is so terminated is entitled to the procedural rights provided in Article 12 of the Medical Staff Bylaws for the sole purpose of determining the issue of good cause

Medical Staff Services verifies the information provided on the reappointment application working with the same authorities and generally in the same manner as provided in section 1.5.2 for the initial application process. Peer references will be collected for faculty with insufficient activity. Current hospital affiliations, licensure, NPDB, sanctions and malpractice claims history verification will be verified as per the procedure outlined in section 1.5.2. Medical Staff Services notifies the staff member, with a copy to the Chairman, of any information inadequacies or verification problems. This notice must indicate the nature of any additional information the staff member is to provide and the time frame for response. Failure, without good cause, to respond in a satisfactory manner by that date is deemed a voluntary resignation of appointment and all clinical privileges.

2.2.2 From Internal Sources

The Chairman of the Credentials Committee, or his designee, collects for review at the time of reappointment all relevant information regarding the individual's professional and collegial activities, performance and conduct in the Medical Center. Such information, together with the information obtained under this section shall form the basis for recommendations and actions. The information gathered from internal sources shall include, without limitation:

(a) patterns of care and utilization as demonstrated in the findings of quality review, risk management and utilization management activities (as compiled in the physician reappointment profile);

(b) level/amount of clinical activity at the Medical Center. Confidential evaluations will be sought from all other hospitals where the physician is clinically active.

(c) sanctions imposed or pending and other problems;

(d) timely and accurate completion and preparation of medical records;

(e) current ability to perform professional duties**;**

(f) all other pertinent information that may be relevant to the staff member's status and privileges at this Medical System including the staff's member's activities at other hospitals and his medical practice outside the Medical System.

2.3 Department Evaluation

Each Chairman of each service in which the staff member requests or has exercised privileges reviews the reappointment application, its supporting information, the information gathered under Section 2.2.2 above, and other pertinent aspects of the staff member's file including the following:

(a) demonstration of clinical competence;

(b) demonstration of appropriate judgement;

(c) ability to perform professional duties;

(d) clinical activity;

(e) sense of responsibility and ethics;

(f) attitude, cooperation and ability to get along with others;

(g) ability to establish effective relationships with patients;

(h) compliance with Medical Staff Bylaws and Rules and Regulations;

(i) attendance at department and other meetings;

(j) support for teaching programs; and

(k) compliance with continuing medical education requirements.

The Chairman shall evaluate the information for continuing satisfaction of the qualifications for staff appointment, the category of assignment and the privileges requested. If the Chairman requires further information, he shall notify, through Medical Staff Services, the staff member and the Credentials Committee Chairman in writing of the information required. Failure without good cause to respond in a satisfactory manner by the time specified is deemed a voluntary resignation of appointment and all clinical privileges. Each applicable Chairman forwards to the Credentials Committee a written report with recommendations for, and any special limitations on, reappointment or non-reappointment and staff category, department and clinical privileges. If no such recommendations are made, the reason must be stated. Included in any Chairman's report must be any action or information contained in the department files that was not previously transmitted for inclusion in the staff member's credentials file concerning his clinical performance, fulfillment of medical staff membership or category obligations, or satisfaction of any other qualifications for appointment or the clinical privileges granted. The Chairman may also recommend changing the staff status to Courtesy or Associate at the time of reappointment.

2.4 Reappointment of Department Chairman

The same procedures outlined in Section 2.2.1 and 2.2.2 will be followed when a Chairman is eligible for reappointment. A reference evaluation will be obtained from an active faculty member of the Chairman’s Department. The Chief Medical Officer will review the reappointment application, requested delineation of privileges and physician reappointment quality profile and recommends approval to the Credentials Committee.

2.5 Credentials Committee Evaluation

The evaluation and review of the reappointment application follows the procedure set forth in Section 1.5.4. For purposes of reappointment, the terms "applicant" and "application" as used in said Sections shall mean respectively, "staff member" and "reappointment".

2.6 MEC and Board Action

Final processing of reappointment follows the procedure set forth in Section 1.5.5 through 1.5.8. For purposes of reappointment, the terms "applicant" and "application" as used in said Sections shall mean respectively, "staff member" and "reappointment".

2.7 Basis for Recommendations and Actions

Each individual or group providing a recommendation or acting on a reappointment shall have available the full resources of the medical staff and Medical Center as well as the authority to use outside consultants as necessary. The report of each such individual or group required to act on a reappointment shall state the reasons for each adverse recommendation made or action taken, with specific reference to the member's credentials file and all other documentation considered. In addition, to any other information contained in a credentials file that may support a non-reappointment recommendation, those providing a recommendation or action may consider no or very minimal involvement in patient care at the Medical Center by a staff member over the last period of appointment, as grounds for a recommendation or action to not reappoint or to deny particular privileges. Any dissenting views at any point in the process must be documented including the reason for the differing view and the information on which it is based and the alternative recommendation, if any. Any minority position must be transmitted with the majority report

2.8 Time Periods for Processing

Transmittal of the notice to a staff member and his providing updated information is to be carried out in accordance with Section 2.1.1 of this manual. Thereafter and except for good cause, all persons and groups required to act must complete such action so that the Board of Directors acts all reappointment reports and recommendations on prior to the expiration date of staff appointment of the member whose reappointment is being processed. The time periods specified are to guide the acting parties in accomplishing their tasks. If delay without good cause occurs at any step in the processing and is attributable to a medical staff or hospital authority, the next higher authority may immediately proceed to consider the reappointment application and all the supporting information or may be directed by the President of the Medical Staff on behalf of the MEC or by the Chief Executive Officer on behalf of the Board of Directors to proceed.

If the delay is attributable to the practitioner's failure to provide information as required by section 2.1.1 or failure to request an extension, the staff appointment terminates on the expiration date as provided therein. An appointment extension is not to be deemed to create a right of automatic reappointment for the coming term.

PART THREE: PROCEDURES FOR DELINEATION OF CLINICAL PRIVILEGES

3.1 Department Responsibility for Approach to Delineating Privileges

Each clinical department makes recommendations to the Medical Staff regarding professional criteria for clinical privileges. The clinical department defines, in writing, the operative, invasive and other special procedures, within its area of clinical practice engaged in at the Medical Center. These definitions must be incorporated into the instruments used for the requesting and granting of privileges and must be approved by the Credentials Committee and Medical Executive Committee. The delineating instruments must be revised as necessary to reflect new procedures, instrumentation, treatment modalities and like advances or changes. All privilege forms are created using a standard format utilizing a category format and defining specialized procedures with the levels of training or expertise required for eligibility in each category.

3.2 Consultation and Other Conditions

3.2.1 In General

As part of his request for clinical privileges, each practitioner agrees that he will seek appropriate consultation or refer to another qualified practitioner when appropriate. Each practitioner also acknowledges that his request for, and exercise of privileges are circumscribed by hospital and medical staff policies as may from time to time be in force.

3.3 Procedure for Delineating Privileges

3.3.1 Requests

If the applicant is applying for privileges in two different departments/specialties, the practitioner must meet the privileging requirements set forth by each specialty and have a current faculty appointment with the University of Maryland School of Medicine.

Each application for appointment and reappointment to the medical staff must contain a request for the specific clinical privileges desired by the applicant or staff member.

Specific requests must also be submitted for temporary privileges and for modifications of privileges in the interim between reappraisals.

3.3.2 Processing Requests

A request for clinical privileges, except for temporary privileges, is processed according to the procedures outlined in Part One of this manual if it is by a practitioner not currently a member of the staff or according to those outlined in Part Two if it is by a current Staff member.

PART FOUR: TEMPORARY CLINICAL PRIVILEGES

4.1 VISITING TEMPORARY PRIVILEGES

4.1.1 Circumstances

In cases of medical necessity, visiting temporary privileges may also be granted to a practitioner for the care of specific patients (but not more than thirty (30) days during a calendar year) provided that the following procedure is followed.

4.1.2 Procedures

The following materials are to be submitted to Medical Staff Services for processing:

(a) a completed visiting temporary privileges application signed by the applicant;

(b) a copy of the applicant's current Maryland license or current license in another jurisdiction if the applicant's practice is outside the state, in which case, evidence of approval to practice medicine should be obtained from the Board of Physicians;

(c) evidence of current Drug Enforcement Agency (DEA) registration;

(d) evidence of professional liability insurance in the minimum amount required by the Board of Directors;

(e) a written request for visiting temporary privileges signed by the Chairman and Division Chief including a detail of the procedures and services to be performed by the applicant during this time period; and

(f) an evaluation form the applicant’s primary hospital confirming the practitioner’s ability to perform privileges requested.

Medical Staff Services shall verify the accuracy of the above information and forward the completed materials to the President of the Medical Staff and Chief Executive Officer for approval. The applicant and the Chairman shall be notified by written notice of the final decision.

4.2 TEMPORARY PRIVILEGES

4.2.1 Urgent Patient Care NeedTemporary privileges may be granted to a practitioner for a specified period of time (no longer than 120 days) when an urgent patient care need has been identified and documented and is deemed necessary by the President of the Medical Staff and the Hospital CEO, or his designee. Such a person may provide coverage for a period not to exceed the period specified, unless the President of the Medical Staff, or his designee, recommends a longer period for good cause.

4.2.2 Procedures

Upon the written recommendation of the Chairman of the department where privileges will be exercised, the President of the Medical Staff and the Chief Executive Officer or his designee, may grant temporary privileges as outlined in the Medical Staff Bylaws, provided the following items have been obtained:

(a) Completed application and signed Consent to Release Information form for Medical/Affiliate Staff membership with no missing time periods greater than three months;

(b) Verification of current Maryland state license;

(c) Current DEA (or acknowledgement that controlled substances may not be prescribed/administered until received);

(d) Current CDS (or acknowledgement that controlled substances may not be prescribed/administered until received);

(e) Proof of adequate professional liability coverage and explanation of any prior malpractice claims;

(f) Two satisfactory evaluations from responsible Medical Staff authorities where the applicant has been trained or affiliated within the last 5 years;

(g) Delineation form completed by the applicant and approved by the Chairman and Division Chief, if applicable;

(h) National Practitioner Data Bank (query only);

(i) Verification of Medical School/Dental School Degree;

(j) Verification of ECFMG Certification (if applicable);

(k) Current Curriculum Vitae;

(l) Letter of Need for granting temporary privileges from the Chairman of the department where privileges will be exercised;

(m) Satisfactory resolution of any questions or concerns raised by the information thus far collected.

(n) Current PPD Skin Testing results (within 1 year)

(o) Verification of Medicare/Medicare Sanction Check

(p) Proof of moderate sedation criteria if requesting moderate sedation privileges

(q) Verification of criminal history

(r) Approval by the Director of Medical Staff Services, Department Chairman, Credentials Committee member and President of the Medical Staff Organization.

4.3 Temporary Pending Review by MEC and Board Approval

4.3.1 Temporary Privileges may be granted to an applicant when primary source verification/processing has been completed by Medical Staff Services, and the applicant is waiting for review, recommendation and approval by the organized Medical Staff and governing body. Applicants may not be considered for temporary approval in this situation if there is a current or previously successful challenge to licensure or registration, involuntary termination of medical staff membership or limitation, reduction, denial or loss of clinical privileges at another institution, or any unusual pattern of or excessive number of professional liabilkity actions resulting in a final judgment against the applicant.

4.3.2 Procedure

Applicant will meet all requirements under 1.5. Application will be reviewed by the Director of Medical Staff Services, Department Chairman, Credentials Committee member and President of the Medical Staff Organization.

PART FIVE: APPROVED AND UNAUTHORIZED LEAVES OF ABSENCE

5.1 Approved Leaves

5.1.1 Requesting and Granting a Leave

A Medical/Affiliate Staff Member in good standing may take a leave of absence upon thirty (30) days prior written notice to the Medical Executive Committee stating the actual period of the leave desired, which may not exceed twelve (12) months or be less than thirty (30) days, the reason for the leave and a description of the activity that will occur during the leave. During the period of the leave, the Member shall not exercise clinical privileges at the Medical Center, and membership rights and responsibilities shall be inactive, but the obligation to pay dues and assessments, if any, shall continue, unless waived by the Medical Staff. The foregoing notwithstanding, prior to taking leave, the Member must make appropriate arrangements to ensure that any then existing administrative or clinical responsibilities will be properly discharged during the period of his/her leave.

5.1.2 Reinstatement or Extension at Conclusion of Leave

At least 10 days prior to the termination of the leave of absence, the Medical/Affiliate Staff Member will provide written notice to the Medical Executive Committee of his/her return from leave. If the Member's appointment has expired during the leave of absence, he/she will be deemed to have voluntarily resigned from the Medical Staff with no applicable due process rights under Article 12 hereof and shall be required to reapply.

PART SIX: REQUEST FOR MODIFICATION OF APPOINTMENT STATUS OR PRIVILEGES, RESIGNATIONS AND REPORTING

6.1 Request for Modification of Appointment Status or Privileges and Notice of Relinquishment of Privileges

A staff member may, either in connection with reappointment or at any other time, request modification of his staff category, department assignment, or clinical privileges by submitting a written request to Medical Staff Services. A modification request must contain all pertinent information supportive of the request and is processed according to the procedures outlined in Part Two of this manual. Prior to Credentials Committee evaluation, verification with primary sources external to the Medical Center and compilation of such internal data as necessary to properly evaluate the request will be collected.

Verifications include:

(a) State licensure

(b) National Practitioner Data Bank (NPDB)

(c) Medicare/Medicaid Sanctions

A staff member who determines to no longer exercise, or to restrict, or limit the exercise of particular privileges which he has been granted shall send written notice to the Medical Staff President and the appropriate Chairman indicating the same and identifying the particular privileges involved and, as applicable, the restriction or limitation. This notice shall be included in the member's credentials file.

All requests are subject to Credentials Committee and Medical Executive Committee approval.

6.2 Resignation of Staff Appointment

A staff member may, at any time, resign his staff appointment by giving written notice to the Chairman. Such resignation letter shall specify the reason therefor and the effective date. A practitioner who resigns his staff appointment is obligated to fully and accurately complete, with signatures, all portions of all medical records for which he is responsible prior to the effective date of the resignation. If this obligation is not fulfilled, documentation will be recorded in the practitioner's permanent credentials file and will be used when supplying references to other institutions.

Resignations are to be forwarded to Medical Staff Services, and subsequently to the Credentials and Medical Executive Committees for acceptance.

6.3 Reporting Requirements

The hospital shall comply with any reporting requirements of the Board of Directors as well as those applicable under the Health Care Quality Improvement Act of 1986 and Maryland state law. Following a formal peer review process, and/or at the time the hospital reduces, limits, revokes, restricts or suspends the clinical privileges of a practitioner for greater than 30 days, or accepts the practitioner's surrender of clinical privileges while under investigation by the hospital regarding possible incompetence or improper professional conduct, the hospital is required to notify the National Practitioner Data Bank (NPDB), and the appropriate licensing agency (Maryland Board of Physicians, Maryland Board of Dentistry, Maryland Board of Examiners of Psychologists, Maryland Board of Nursing, etc). This includes suspension or termination due to patient care quality issues. The NPDB report will be submitted electronically, in accordance with NPDB requirements at the following website: www.npdb-hipdb.com. NPDB reports will be filed with said agency within 15 calendar days Appropriate state licensing agencies will be notified in writing of any action within the time frame prescribed by each agency.

PART SEVEN: CONFIDENTIALITY

7.1 All credentialing information is maintained under the strictest confidence in accordance with The Joint Commission (TJC), NCQA, HIPAA, state law and guidelines set forth by the University of Maryland Medical Center.

(a) All active credentials files are stamped "CONFIDENTIAL" on the front cover.

(b) All active and inactive credentials files are maintained in a secure, locked room. Medical Staff Services maintain the only keys to this area. Files archived to an off-site location are marked confidential.

(c) Credentials Committee members shall be required to sign a confidentiality agreement at the beginning of their term.

(d) Copies of Credentials Committee meeting agendas and committee minutes are kept in the Medical Staff Services Office in labeled binders. Binders are available for review in the presence of a Medical Staff Office staff member by appointment only.

(e) A practitioner may review his/her credentials file only in the presence of a Medical Staff Services employee by appointment. In no case shall the practitioner remove or make copies of any material in his/her file other than what he/she supplied or if said document is addressed directly to the practitioner.

(f) Members of Managed Care Organizations who audit UMMC credentials files must sign a confidentiality statement to ensure confidentiality standards.

(g) Consultants or attorneys engaged by this hospital may be granted access to records that are necessary to enable them to perform their functions.

(h) Representatives of regulatory or accreditation agencies may have access to records.

(i) Authorized representatives from organizations for whom this hospital performs delegated credentialing services may have access to records pertaining to their applicants or participating providers, provided that each applicant or participating provider has completed a satisfactory authorization and release form.

(j) All subpoenas pertaining to records shall be referred to the authorized representative, who shall first consult with legal counsel regarding appropriate response.

(k) All documents that are scanned for credentialing purposes (i.e. Licenses, Credentialing Applications, Curriculum Vitae, Malpractice Insurance certificates, Evaluations, Delineation of Privilege forms) are confidential documents and protected on a secured server. The database in which these documents are saved is available to Medical Staff Office personnel only via a password-protected secured database. In addition, email sent and received regarding the credentialing status of providers is protected under the hospital's email security policies.

PART EIGHT: MAINTENANCE OF THE CREDENTIALS FILE

8.1 All active credentials files will be maintained by Medical Staff Services as outlined below. A separate credentials file is maintained for each individual requesting medical staff membership or clinical privileges.

(a) All incoming documents shall be date-stamped and initialed upon receipt in the Medical Staff Services Office. Per NCQA standards, all documents and verifications received relating to a practitioner's file must be date stamped and initialed. These documents include but are not limited to:

(i) Application and Curriculum Vitae

(ii) Renewal copies of state medical/dental/professional license, Federal Drug Enforcement Agency (DEA) registration, Maryland Controlled Dangerous Substances (CDS) registration, ACLS, BCLS, PALS, ATLS and/or NRP certificates, board certification and/or malpractice insurance certificate;

(iii) Verification letters from current and prior affiliations, all educational institutions which verify education and post graduate training, peer reference evaluations;

(iv) All subsequent reappointment applications and

(v) Delineation of privilege forms.

(b) Maryland Medicine Comprehensive Insurance Program

Practitioners covered by the Maryland Medicine Comprehensive Insurance Program (MMCIP) are provided malpractice coverage by the University of Maryland Medical Center's self-insurance trust.

The policy period of this coverage begins on July 1 and ends on June 30 annually. At the time of initial enrollment and reappointment, MMCIP will forward a letter verifying coverage to the practitioner. At the end of the policy year, MMCIP shall provide a roster of renewed practitioners to Medical Staff Services, who shall update the credentialing database with the current policy period.

8.2 Site Visit and Medical Record Review reporting

As part of delegated credentialing contracts with various Managed Care Organizations, site visit and medical record reviews for all participating providers are conducted every two years. The reports are utilized during MCO delegated credentialing audits to document site visits of UMMS approved clinical sites.

UPI Practice Operations staff will conduct a site visit to in order to assess the safety and accessibility of the practice site. Practice management, medical records and clinical management staff will be reviewed during the site visit. Within two weeks of the site visit, scoring results are completed. Follow-up visits are scheduled within three weeks of the audit. Practice leadership will develop an action plan to rectify any deficiencies noted within 30 days. The corrective action plan will be reviewed and approved by the Clinical Service Standards Committee and forwarded to the Medical Staff Office. Statistics will be kept by practice over time. The site audits must be performed no less than every two years. All standards and thresholds must be met in order for a site to pass inspection. Practices with deficiencies against defined thresholds will be reviewed every six months until action plan improvements have been completed. These visits will also be documented for the file.

On an ongoing basis, patient complaints are monitored and when appropriate, sites will be re-evaluated based on patient feedback. Effective July 1, 2008, if there are sufficient complaints made by members, any specialty practice site will have a site visit performed within 60 days to address the member concerns.

All reports and information submitted by the FPI Practice Operations Office will be kept in the Medical Staff Office in a labeled binder.

8.3 Licensure Renewal

Upon expiration of Maryland State licensure, Medical Staff Services will verify the renewal of said license via the Maryland Board of Physicians/Maryland Board of Dentistry, Maryland Board of Examiners of Psychologists, Maryland Board of Nursing, etc websites or via communication from an authorized Board representative. If the license is not renewed by the expiration date, the practitioner will be suspended from the Medical/Affiliate Staff of the University of Maryland Medical Center until such time as their license is renewed and verified by Medical Staff Services. (Medical Staff Bylaws, Section 11.3-1) Upon renewal, the practitioner's status will return to its status prior to the suspension. If a period of 30 days has elapsed, the applicant will be required to reapply for medical/affiliate staff privileges and membership at the University of Maryland Medical Center.

PART NINE: ONGOING MONITORING ACTIVITIES

9.1 Quality Improvement Data Report

Provider clinical quality data is collected at the time of reappointment for all physicians, dentists, podiatrists and psychologists. This report includes but is not limited to the following indicators:

(1) inpatient admissions
(2) inpatient days
(3) non-acute days
(4) denied days
(5) # of operative procedures
(6) preventable quality events
(7) inpatient mortality
(8) appropriate blood utilization
(9) blood consents present
(10) verbal order compliance

(11) H&P done within 24 hours
(12) reassessment done per policy
(13) patient relation compliments
(14) patient relation complaints
(15) number of risk incidents
(16) number of open claims
(17) number of infections
(18) drug utilization evaluations
(19) number of avoidable re-admissions

The Chairman of the applicable Department will be required to review and sign the Quality Improvement Data Report prior to submission to the Credentials Committee. Upon approval, this information will be placed in the back of applicable credentials files in a separate folder marked "Confidential Peer Review Information". The information included in this report is compiled from an internal database that is maintained by the Quality Management Department which reports the data to the Performance Improvement Steering Committee. This committee is comprised of representatives from clinical department quality committees, and department-specific quality reports are reviewed on a rotating schedule, and then subsequently to the Medical Executive Committee. The duties of the Performance Improvement Steering Committee may be found in the Medical Staff Bylaws Section 8.5.

9.2 Ongoing Monitoring of Practitioner Practice

Ongoing evaluation information is factored in to the decision to maintain an existing privilege, revise an existing privilege, or revoke an existing privilege. Practitioner-specific quality profiles using indicators approved by the Medical Executive Committee will be completed a minimum of every 9 months. For any medical staff member without sufficient reviewable volume at University of Maryland Medical Center will be asked to supply similar data from their primary facility. Areas to be assessed include:

- Patient Care
- Medical Knowledge
- Practice-based Learning and Improvement
- Interpersonal Skills and Communication
- Professionalism
- Systems-based practice

The Medical Staff Services Department will coordinate the collection and review of profiles for the individual practitioners. The profiles will be forwarded to the appropriate Service Chair or Section Chief for completion which will include a recommendation as to whether privileges are to be maintained, revised or revoked. The decision will be documented in the practitioner's credentials file in the Medical Staff Services Department. Recommendations other than maintenance of privileges will be communicated to the practitioner.

9.3 Member Complaints

The Patient Representative Office is responsible for the investigation and handling of member complaints and compliments. If a patient has a complaint regarding care provided, the Patient Representative researches the claim, interviews the patient, hospital staff that may have been involved and works directly with the clinical staff to resolve disputes. The Patient Representatives' findings from any investigation, including recommended actions are shared directly with the Department Chairman and/or Division Chief. The Medical Staff Office is not directly involved with the handling of member complaints or compliments.

9.4 Performance reports received from delegated managed care entities

Upon receipt, performance information including member complaints and remedial actions received from delegated managed care organizations under delegated credentialing contracts will be sent for

review and signature by the Department Chairman. If necessary, any remedial action ordained by the managed care company will be reiterated by the Medical Staff Office to the Chairman to reinforce the necessity of compliance with said regulations. Said reports will be included with Quality Improvement Data reports at the time of reappointment for review and signature by the Department Chairman, to present a full perspective of the providers' quality of care during the last reappointment cycle.

9.5 Review of monthly sanction reports

Effective July 1, 2001, Medical Staff Services will review sanction reports from the U.S. Office of Inspector General, the State of Maryland and any other State in which UMMC applicants are currently practicing to identify any practitioner having medical staff privileges and membership at the University of Maryland Medical Center. These reports will be reviewed within 30 days of availability, and if an UMMC practitioner has been sanctioned, the procedure set forth in the Medical Staff Bylaws, Section 11.3-1 will be followed.

In addition, the office will run a monthly review of Medicare Opt-Out Affidavits data (via https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/opt-out-affidavits) and follow the afore-mentioned procedure detailed in Bylaws for any matched practitioner.

9.6 Managed Care Reporting

On a monthly basis, a report will be sent to the Managed Care Office detailing newly credentialed and recredentialed participating providers, applicable practice locations and resignations. This report will be sent in a Microsoft Excel format. The Managed Care Office manages the distribution of all monthly and quarterly reports to participating Managed Care Organizations with regard to the University of Maryland Medical Center contracts. Quarterly, the Managed Care Office will verify data in the active file with each clinical department to ensure accuracy of the participating provider listing. Medical Staff Services performs all updates to provider status. Annually, the Managed Care Office reconciles the participating provider database with the database maintained in Medical Staff Services to ensure accuracy. According to applicable delegated credentialing contracts, the University of Maryland Medical Center does not report any provider that chooses to "opt-out" of Medicare. Such providers are considered to be 'Non-Participating" providers and marked same in the provider credentialing database.

PART TEN: SCOPE OF CREDENTIALING

10.1 Medical Staff Services of the University of Maryland Medical Center performs the credentialing for the University of Maryland Medical Center Medical Staff Services does not contract with outside sources to perform any portion of the credentialing process. All primary source verifications are done by Medical Staff Services. Credentialing is required for all dentists, physicians, podiatrists, psychologists and allied health practitioners (which include nurse anesthetists, nurse practitioners, nurse midwives and physician assistants) working in the hospital or affiliated locations. In some cases, Medical Staff Services may utilize the AMA Profile Service for verification of medical degree, residency and fellowship completion.

Organizational providers (home health agencies, partial hospital, chemical dependency and rehabilitation centers) are not included within the credentialing of the University of Maryland Medical System.

10.2 System Credentialing

Effective June 2014, the University of Maryland Medical System Corporation d/b/a University of Maryland Medical Center, Maryland General Hospital d/b/a University of Maryland Medical Center Midtown Campus, James Lawrence Kernan Hospital, Inc., d/b/a University of Maryland Rehabilitation and Orthopaedics Institute, Baltimore Washington Medical Center, Inc., d/b/a University of Maryland Baltimore Washington Medical Center, Memorial Hospital of Easton,

d/b/a University of Maryland Shore Medical Center at Easton, Dorchester General Hospital, d/b/a University of Maryland Shore Medical Center at Dorchester, Chester River Hospital Center, d/b/a University of Maryland Shore Medical Center at Chestertown, or Civista Medical Center, Inc. d/b/a University of Maryland Charles Regional Medical Center, University of Maryland St. Joseph Medical Center, LLC, d/b/a University of Maryland St. Joseph Medical Center, University of Maryland Upper Chesapeake Health System, Inc., d/b/a University of Maryland Upper Chesapeake and University of Maryland Harford Memorial Hospital, and any successor, or assignees of the foregoing, and any other designee of the University of Maryland Medical System Corporation, or of any facilities associated with the University of Maryland Medical System Corporation share credentialing documents in an effort to streamline the credentialing process.

The UMMC Department Faculty Coordinator will identify the primary hospital location for the provider. This hospital will complete the primary source verification for the applicant and share with other System Hospitals where the provider will be credentialed. By signing the shared consent form, the provider permits the sharing of the credentials file. All materials will be scanned and shared via each Medical Staff Services Office (and MMCIP if necessary). Upon completion of the credentials file and approval of the faculty appointment, the provider will be presented to the next regularly scheduled Credentials Committee at each hospital facility for approval. Each System Hospital will maintain local approval of the provider.

Documents to be shared include but are not limited to the following:

Credentialing application and addendum
Curriculum Vitae
Privilege forms
Copies of all licenses and drug registrations (DEA/CDS)
Copies of board certification certificates, BCLS/ACLS/PALS/NRP, as applicable
Copies of GME education certificates
Malpractice insurance certificates and claims history information
All primary source verifications to include: licensure, sanction, board certification, claims histories, education, training, hospital affiliations
Peer review evaluations
Quality and utilization data (if applicable)
References completed on UMMS approved shared evaluation

Documents that will not be shared include but are not limited to the following:

National Practitioner Data Bank

10.3 Credentialing Systems Controls

Primary Source Verification (PSV) – as described in the Primary Source Verification section of this Credentialing Procedures manual, PSV is primarily obtained through queries to the appropriate verification websites for licensure, board certification and education, etc. All documents that are reviewed and loaded by the Medical Staff Office Team Member are digitally tracked in the audit log, digitally date stamped and stored in the MD Staff credentialing database and is a permanent record of the providers' profile.

Tracking Modifications

All modifications to PSV are documented and date stamped electronically. All other necessary modifications are made by Medical Staff Team Member who have been issued secure access to MD Staff and are authorized to make such changes. Modifications are tracked electronically by the software and are permanently documented in the provider profiles.

Authorization to Modify Information

The Medical Staff Office Team consists of the Director, Credentialing & Information Systems Manager, Medical Staff Coordinators and Credentials Assistant, each of whom has secure access to MD Staff and are authorized to make necessary changes. All changes are tracked permanently in the software, with the users' name and date change was made and are documented for historical reference. Modifications are typically made when licensure is renewed, and MD Staff automatically updates the information and pulls the image of the updated license into the provider record from the official verification websites. Deletions rarely take place, but when they do it is done to remove an inaccurate verification from the verification log. The system has "bugs" that cause negatively marked items when they are not in fact negative, this is a situation where deletion is allowed. The true verification that is deleted must be ran manually outside of the system and uploaded to the verification log of MD Staff. Other deletions are allowed when a document or verification is uploaded erroneously to an incorrect applicant. Outside of those situations' deletions are not allowed.

Securing Information

All provider data is stored in MD Staff with requires authorized user access. Physical access to and release of provider information is limited to authorized users in order to protect the accuracy and integrity of information gathered from primary and approved sources.

Logins are issued by the Credentialing & Information Systems Manager after completing the MD Staff Confidentiality form. When employees leave the organization, passwords are immediately disabled by the Credentialing & Information Systems Manager and Information Service and Technology is alerted to end access. Users are required to use strong passwords, prohibited from writing down passwords, and must use different passwords for different accounts.

Credentialing Process Audit

The Credentialing & Information Systems Manager and the Medical Staff Services Director, performs routine audits of system control policies and procedures to identify and assess any risks to the provider data contained in MD Staff. Random audits of 10 provider files are conducted monthly while staff are preparing the monthly credentials list for submission to Credentials Committee. The summary report is distributed to the Medical Staff Services Director, Chief Medical Officer and/or President of Medical Staff who provide oversight of the audit process.

PART ELEVEN: AMENDMENT

11.1 Amendment

This credentialing procedures manual shall be reviewed at least annually by the Credentials Committee and may be amended or repealed, in whole or in part, by one of the following mechanisms:

(a) a resolution of the Medical Executive Committee (MEC).

(b) action by the Board of Directors on its own initiative after notice to the MEC of its intent.

Approved: Credentials Committee, 3/6/96
Approved: Medical Executive Committee, 3/26/96

Approved: Credentials Committee, 4/21/99
Approved: Medical Executive Committee, 4/28/99

Approved: Credentials Committee, 4/00
Approved: Medical Executive Committee, 4/00

Approved: Credentials Committee, 11/00
Approved: Medical Executive Committee, 11/00

Approved: Credentials Committee, 10/01 and 11/01
Approved: Medical Executive Committee, 11/01

Approved: Credentials Committee, 5/03
Approved: Medical Executive Committee, 5/03

Approved: Credentials Committee, 9/03
Approved: Medical Executive Committee, 9/03

Approved: Credentials Committee, 4/04
Approved: Medical Executive Committee, 4/04

Approved: Credentials Committee, 9/04
Approved: Medical Executive Committee, 9/04

Approved: Credentials Committee, 5/06
Approved: Medical Executive Committee, 5/06

Approved: Credentials Committee, 6/07
Approved: Medical Executive Committee, 6/07

Approved: Credentials Committee, 8/07
Approved: Medical Executive Committee, 9/07

Approved: Credentials Committee, 11/07
Approved: Medical Executive Committee, 11/07

Approved: Credentials Committee, 2/08
Approved: Medical Executive Committee, 2/08

Approved: Credentials Committee, 3/08
Approved: Medical Executive Committee, 3/08

Approved: Credentials Committee, 7/08
Approved: Medical Executive Committee, 7/08

Approved: Credentials Committee, 12/08
Approved: Medical Executive Committee: 12/08

Approved: Credentials Committee, 9/09
Approved: Medical Executive Committee: 9/09

Approved: Credentials Committee, 7/10
Approved: Medical Executive Committee: 9/10

Approved: Credentials Committee, 1/11
Approved: Medical Executive Committee: 2/11

Approved: Credentials Committee, 7/12
Approved: Medical Executive Committee: 8/12

Approved: Credentials Committee, 11/14
Approved: Medical Executive Committee: 11/14

Approved: Credentials Committee 8/17

Approved: Medical Executive Committee 8/17

Approved: Credentials Committee 12/3/2020
Approved: Medical Executive Committee 12/16/2020

Approved: Credentials Committee 6/15/2022
Approved: Medical Executive Committee 6/22/2022

ANNUAL REVIEWS

Credentials Committee shall annually review the procedures manual as part of their function as Committee.

Approved: Credentials Committee 11/2021
Approved: Medical Executive Committee 11/2021
Changes (where applicable):