Medical Staff Bylaws: Compliance Challenges
Updating Bylaws to Comply with Joint Commission Standards

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MEDICAL STAFF
BYLAWS COMPLIANCE
ISSUES

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Agenda

- Overview of Recent Developments
  - Revised Joint Commission Standards (MS.01.01.01)
  - Interpretive Guidelines for Existing CoPs
  - Patients’ rights and the LGBT Community
  - Telemedicine
  - Proposed CoPs

- Best Practices and Enforcement Issues
Overview of Revised – MS.01.01.01

• Composition of Medical Staff
• What needs to be in the bylaws
• Conflict Management
• Amendment Process
“Medical staff bylaws address self-governance and accountability to the governing body.”

- This concise standard is followed by 36 Elements of Performance.
- Nine of which were revised when MS.01.01.01 was finally adopted.
- Goal of standard revision was to:
  - Align TJC bylaws requirements with CoPs; and
  - Enhance patient safety and quality of care by improving communication between medical staff members, MEC, and the Governing Body.

http://www.jointcommission.org/assets/1/18/MS_01_01_01.pdf
Composition of Medical Staff

- Medical Staffs have been expanded to include M.D.s, D.O.s and “other practitioners [who] are organized into a self-governing medical staff. . . who are privileged through a medical staff process.” This may include Podiatrists, Psychologists, Nurse Practitioners & Physician Assistants and others.

  - Important to review state law to determine if any limitations on membership exist.

  - Consistent with 42 CFR §482.22(a). See Revisions to Hospital Interpretive Guidelines Appendix A, CMS Manual System, Transmittal 78, Effective Date December 2, 2011.
Bylaw Development

- EP 1 - OMS develops bylaws, rules and regulations, and policies.
- EP 2 - OMS adopts and amends medical staff bylaws.
  - Adoption or amendments of bylaws cannot be delegated.
  - Bylaws become effective upon governing body approval.
  - EP cites to requirements regarding governing body authority and conflict management processes, if there is a disagreement between medical staff leadership regarding the bylaws, as well as to EP 17 which states that medical staff determines through its bylaws who can vote.
EP 3  What Needs to be in the Bylaws

- Every requirement set forth in EP12 through EP36 must be in the bylaws.
- These requirements may have associated details, some of which may be extensive, such details may reside in the bylaws, rules, regulations or policies.
- OMS adopts what constitutes the associated details, where they reside, and whether their adoption can be delegated.
- Adoption of associated details that reside in the bylaws can not be delegated.
- For EP 12 through 36 that require a “process”, bylaws must include, at a minimum, “basic steps” required for implementation of the requirement as approved by OMS and the governing body.
- OMS submits its proposals to the governing body for action.
- Proposals become effective only upon governing body approval.
- If there is a conflict, the governing body must follow conflict management procedures under Leadership Standards.
Elements of Performance in Bylaws

- EP 12 - Structure of the Medical Staff.
- EP 14 - Process for privileging and re-privileging LIPs and others.
- EP 15 - Statement of duties and privileges relating to each category of the Medical Staff.
- EP 17 - Description of those members who are eligible to vote.
- EP 18 - Process by which OMS selects and removes medical staff officers.
- EP 19 - A list of all the officer positions for the medical staff.
- EP 20 - MEC’s function, size, and composition as determined by the OMS and approved by the governing body; the authority delegated to the MEC and how such authority is delegated or removed.
Elements of Performance in Bylaws

- EP 21 - Process, as determined by the OMS and approved by the governing body, for selecting and/or electing and removing the MEC members.

- EP 22 - MEC includes physicians and may include other practitioners and any other individuals as determined by the OMS.

- EP 23 - MEC acts on behalf of medical staff between meetings of the OMS within the scope of its responsibilities as defined by the OMS.


Elements of Performance in Bylaws

- EP 26 - Process for credentialing and recredentialing LIPs and other practitioners.
- EP 28 - Indications for automatic suspension of a practitioner’s medical staff membership or clinical privileges.
- EP 30 - Indications for recommending termination or suspension of membership or termination or suspension or reduction of clinical privileges.
- EP 31 - The process or automatic suspension of membership or privileges.
- EP 32 - The process for summary suspension of membership or privileges.
Elements of Performance in Bylaws

- EP 33 - The process for recommending termination or suspension of membership or privileges.
- EP 34 - The fair hearing and appeal process which, at a minimum shall include:
  - The process for scheduling hearings and appeals;
  - The process for conducting hearings and appeals.
- EP 35 - The composition of fair hearing committee.
- EP 36 - If departments exist, the qualification and rules and responsibilities of the department chair.
The OMS has the ability to adopt medical staff bylaws, rules and regulations, and policies, and amendments thereto, and to propose them directly to the governing body.
EP 9 Adoption of Amendment of Rule, Regulation or Policy

- If voting members of OMS propose to adopt or amend a rule, regulation, or policy, the OMS must first communicate the proposal to MEC.

- If the MEC proposes to adopt or amend a rule, regulation, or policy the MEC:
  - Must first communicate the proposal to the medical staff.
  - MEC can only propose rules, regulations or policies if delegated this authority by OMS with the approval of the governing body.
OMS has to adopt a process to manage conflict between the medical staff and MEC on issues including, but not limited to, proposals to adopt or amend a rule, regulation or policy.

- Medical staff members, meaning anyone on the medical staff, even those with no voting rights, may communicate with the governing body on a rule, regulation or policy adopted by OMS or MEC.
- Governing body determines method of communication.
Conflict Management

- LD.02.04.01 provides that “the hospital manages conflicts between leadership groups to protect the quality and safety of care.”
- Since 2009, Leadership Standards required a written conflict management process, can be in bylaws or a policy.
- Process for managing conflict must be ongoing.
- Process is to be approved by the governing body.
- Individuals involved are skilled in conflict management.
- The conflict management process should include the following:
  - The parties should meet as early as possible to identify the conflict.
  - Must gather information regarding the conflict.
- Hospital implements the process when a conflict arises that, if not managed, could adversely affect the patient’s safety or quality of care.
- Hospital needs to decide what kinds of disputes between OMS and MEC, if any, will trigger conflict management process under the Leadership Standards.
EP 11 Urgent Amendment Process

- If delegated to do so by voting members of OMS, MEC may “provisionally adopt” an amendment to rules and regulations necessary to comply with laws or regulations.
- Need for urgent amendment must be documented.
- Governing body may then provisionally approve amendment without prior notice to the medical staff.
- Medical staff will be immediately notified by MEC.
- Medical Staff has opportunity for retrospective review of and comment on the provisional amendment.
- If no conflict between the OMS and the MEC, the provisional amendment stands.
- If conflict does arise between OMS and MEC, process for resolving conflict between OMS and MEC must be followed.
- Any revisions to the amendment must be submitted to the governing body for final action.
Bylaws must contain a description of those medical staff members who are eligible to vote.
EP 19  MEC Officer Positions

- Bylaws must contain a list of all of the medical staff officer positions.
EPs 24 & 25 Adoption & Amendment of Bylaws, Rules & Regulations and Policies

- EP 24 - Bylaws must contain the process for adopting and amending the medical staff bylaws.

- EP 25 - Bylaws must contain the process for adopting and amending the medical staff rules and regulations, and policies.
Telemedicine

- 42 CFR § 482.22(c)(6) All physicians and practitioners providing patient care must be granted privileges to do so by the governing body and must work within the scope of the privileges granted. Privileges are granted based on the medical staff’s review of the practitioner’s qualifications and the medical staff’s recommendations regarding the practitioner to the governing body. However, in the case of telemedicine physicians and practitioners, the governing body has the option of having the medical staff rely upon the credentialing and privileging decisions of the distant-site hospital or telemedicine entity provided certain conditions are met.

- If this option is exercised by the governing body, the medical staff bylaws must include a provision allowing the medical staff to rely upon the credentialing and privileging decisions of a distant-site hospital or telemedicine entity. See Revisions to Hospital Interpretive Guidelines Appendix A, CMS Manual System, Transmittal 78, Effective Date December 2, 2011.
Telemedicine

- TJC applauded CMS’s new telemedicine credentialing and privileging requirements since the new requirements, which are consistent with TJC’s current rules, remove unnecessary barriers to the use of telemedicine for medically necessary interventions. According to TJC, the updated CoPs will provide more flexibility to hospitals and lessen their regulatory burden.

- Upon adoption of the update telemedicine CoPs, TJC evaluated its telemedicine requirements to ensure that they are aligned with the CMS requirements. On December 14, 2011, TJC posted its final revisions to requirements related to the credentialing and privileging of telemedicine practitioners in hospitals and critical access hospitals. See Standards LD.04.03.09, MS.13.01.01, and MS.01.01.01.
Patient Visitation Rights

- 42 CFR § 482.13(h)
  - (2) requires hospitals to inform each patient (or support person) of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.
  - (3) Hospitals must not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.
Joint Commission Revised Patient Visitation Rights and LGBT Field Guide

- TJC’s revised LGBT-inclusive non-discrimination standard went into effect in July, 2011. The revised standard included elements of performance that prohibit discrimination based on sexual orientation, gender identity, and gender expression, and also ensures access to a support person of the patient’s choice. RI.01.01.01

- New Field Guide Published November 8, 2011
  - *Advancing Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, & Transgender (LGBT) Community*
Proposed CoPs  42 CFR § 482

- § 482.12  Governing Body – Allows hospital systems with more than one CMS certification number to have one governing body.

- § 482.22  Medical Staff
  
  (a) Composition of Medical Staff - CMS seeks to clarify that a hospital may grant privileges to both physicians and non-physicians to practice within their state’s scope of practice. Practitioners may be granted privileges even if they are not members of the medical staff. However, all practitioners with privileges must still follow the rules set forth in §482.22 for Medical Staff.

  (b)(3) - Expands who may be assigned responsibility for organization and conduct of the medical staff to include a Podiatrist when permitted by State law.
§ 482.24(c)(2) Medical Record Services – CMS currently requires all orders, including verbal orders, to be dated, timed and authenticated promptly by the ordering practitioner. There is a five-year exception to this rule, which expires in January 2012, that allows another practitioner to authenticate orders as long as that practitioner is one who is responsible for the patient’s care. All verbal orders must be authenticated in 48 hours, absent a state law requiring another timeframe. CMS seeks to permanently adopt the five-year exception and remove the 48-hour timeframe requirement for authentication of verbal orders. Instead, CMS would defer to hospital policies and state law for timeframes.
QUESTIONS???
Recommended Updates for your Bylaws, Rules, Regulations & Policies

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Advanced Tips for MS.01.01.01

Amendment of the Bylaws

• Traditional Process for Bylaw Amendment is Bylaws Committee to MEC to the Medical Staff to the Board.

• New Process includes Medical Staff directly to the Board.
  • Areas of Concern:
    • Having individual medical staff members (as opposed to the “Medical Staff”) propose amendments to the Board.
    • Sections of the Medical Staff proposing amendments to the Board without Medical Staff leaders being aware of the Amendments or substance of the Amendments.
Advanced Tips for MS.01.01.01

Amendment of the Bylaws

• New Process includes Medical Staff directly to the Board.
  • Possible Solutions:
    • Establish a minimum number of Medical Staff members necessary to propose an Amendment for the Medical Staff to send directly to the Board, i.e. 20%. Then require the Medical Staff to vote on whether such Amendment should go to the Board.

• Provide for a Notice provision to the MEC when an Amendment is being proposed from the Medical Staff Directly to the Board and an opportunity for MEC to comment.
Advanced Tips for MS.01.01.01

Example Language

Bylaw Amendments may also be proposed to the Board by the Medical Staff by majority vote of the members of the Active Staff entitled to vote. Proposed bylaws may be brought before the Active Medical Staff by petition signed by twenty percent (20%) of the members of the Active Staff. Any such proposed bylaw amendment shall be submitted to the Medical Executive Committee for review and comment before it is submitted to the voting members of the Active Staff. Any bylaw amendment approved by a majority of the Active Medical Staff shall again be presented to the Board for final action along with any comments from the Medical Executive Committee.
Advanced Tips for MS.01.01.01

Proposal of Rules, Regulation and Policies

• New Process permits Medical Staff to propose R&R and Policies directly to the Board.
  • Possible Solutions:
    • Rules, Regulation & Policies proposed by MEC do not need to be approved by Medical Staff. However, notice to the Medical Staff and opportunity to comment is advisable.
    • Similar to Bylaw Amendment, if Medical Staff proposes R&R or Policy, require minimum threshold for Medical Staff to consider the proposal and then require a vote by the Medical Staff before making the proposal to the Board.
Advanced Tips for MS.01.01.01

Example Language

• Any proposed rule, or regulation being considered by the Medical Executive Committee shall be distributed to the members of the Medical Staff for review and comment, in accordance with such procedures as are approved by the Medical Executive Committee, before the proposed rule or regulation is adopted by the Medical Executive Committee and sent to the Board for approval.

• Any policy adopted by the Medical Executive Committee and approved by the Board of Directors shall be promptly communicated to the Medical Staff
Example Language

Rules, regulations and policies may also be proposed to the Board of Directors by the Medical Staff by majority vote of the members of the Active Staff entitled to vote. Proposed rules, regulations or policies may be brought before the Active Medical Staff by petition signed by ten percent (10%) of the members of the Active Staff. Any such proposed rules, regulations or policies proposed by a majority of the Active Staff shall be submitted to the Medical Executive Committee for review and comment before such rule, regulation, or policy is voted on by the Active Staff. Any rule, regulation or policy approved by the Active Staff shall be presented to the Board along with any comments from the Medical Executive Committee.
Advanced Tips for MS.01.01.01

Conflict Management

• Must be a process for handling conflict between Medical Staff members, including Medical Staff leaders.

• Does not have to be in the Bylaws, Rules or Regulations but it is advisable to have documented somewhere to show surveyors.
Advanced Tips for MS.01.01.01

Example Language

• In the event of a conflict between members of the Active Staff and the Medical Executive Committee regarding the adoption of any bylaw, rule, regulation or policy, or any amendment thereto, or with regard to any other matter, upon a petition signed by __________ percent (____%) of the members of the Active Staff entitled to vote, the matter shall be submitted to the following conflict resolution process.
Advanced Tips for MS.01.01.01

Example Language

• A Conflict Resolution Committee shall be formed consisting of up to five (5) representatives of the Active Staff designated by the Active Staff members submitting the petition and an equal number of representatives of the Medical Executive Committee appointed by the President of the Medical Staff. The Hospital President/CEO or designee shall be an ex-officio non-voting members of any Conflict Resolution Committee.
Advanced Tips for MS.01.01.01

Example Language

• The members of the Conflict Resolution Committee shall gather information regarding the conflict, meet to discuss the disputed matter, and work in good faith to resolve the differences between the parties in a manner consistent with protecting safety and quality.
Example Language

- Any recommendation which is approved by a majority of the Active Staff representatives and a majority of the Medical Executive Committee representatives shall be submitted to the Board of Directors for consideration and subject to final approval by the Board. If agreement cannot be reached by a majority of the Active Staff representatives and a majority of the Medical Executive Committee representatives, the members of the Conflict Resolution Committee shall individually or collectively report to the Board of Directors regarding the unresolved differences for consideration by the Board of Directors in making its final decisions regarding the matter in dispute.
Example Language

• *In the event of a dispute between leaders or segments of the Medical Staff, the matter in dispute shall be Conflict Resolution Committee composed of equal number of members representing opposing viewpoints who are appointed by the Medical Staff President or the Medical Executive Committee. The members of the Conflict Resolution Committee shall proceed in accordance with Sections 3 and 4. above.*
Advanced Tips for MS.01.01.01

Example Language

• *In the event of a dispute between the Board of Directors and the Organized Medical Staff or the Medical Executive Committee, the matter in dispute shall be submitted to a Joint Conference Committee pursuant to section _____ of these bylaws.*

• *If deemed appropriate by the President of the Medical Staff and the Hospital President/CEO, an outside mediator or facilitator may be engaged to assist with the resolution of any disputed issue.*
Advanced Tips for MS.01.01.01

Qualifications for Medical Staff Membership

• Bylaws to describe the qualifications to be met by a candidate for medical staff membership/privilege. Things to Consider:
  • Any geographical restrictions regarding the location of a practitioner's home or office;
  • Willingness to work with other members of the Medical Staff, health care providers, Hospital administration, management and employees, visitors, and the community in general in the cooperative, professional manner that is essential for maintaining a Hospital environment appropriate to quality patient care;
  • Never having been convicted of a felony or misdemeanor related to suitability to practice medicine.
  • The Hospital has not contracted on an exclusive basis with an individual or group, with which the prospective applicant is not affiliated, to provide the clinical services sought by the applicant.
Privileging of Practitioners - “basic steps” versus “associated details”:

- Processing Applications for Medical Staff Membership and/or Clinical Privileges. 

  **Outline of the Process:**
  - Applicants have the burden of producing adequate information to establish their qualifications and competence.
  - Applications are reviewed for completeness and verified for accuracy.
  - The Department Chair then recommends action.
  - The Credentials Committee next recommends action.
  - The Medical Executive Committee recommends action to the Board.
  - The Board of Directors takes final action on behalf of the hospital.
Advanced Tips for MS.01.01.01

Example Language

• No application for appointment or reappointment shall be accepted for processing and will be deemed incomplete until all information and documents required have been provided and all verifications have been completed. An application for reappointment shall be considered to be incomplete if any applicant for reappointment has not provided requested information or documents, or not responded to requests for comments, concerning peer review or quality improvement matters or any investigation regarding the practitioner’s conduct or qualifications for medical staff membership and privileges.
Example Language

- If any information cannot be obtained or verified, the applicant shall be notified and shall, within sixty (60) calendar days, provide the required information or verification to the Hospital's satisfaction. If the applicant fails to submit the required information or verification within sixty (60) calendar days after being requested to do so, the application shall be deemed to be withdrawn, unless the time to obtain the information is extended by the chair of the Credentials Committee.
Example Language

• No application shall be considered to be complete until it has been reviewed by the department chair, the Credentials Committee and the Medical Executive Committee, and the Credentials Committee and Medical Executive Committee determine that no further documentation or information is required to permit consideration of the application. Additional information may be requested by any department chair, or by the Credentials or Medical Staff Executive Committee.
Example Language

- If membership, clinical privileges, or staff affiliation are not recommended as requested, the Credentials Committee shall set forth the reasons for such recommendation in writing. The applicant shall be notified in writing by the Credentials Committee Chair of the reason(s) for such adverse recommendation and provided an opportunity to submit any information the practitioner wishes the Medical Executive Committee to consider regarding the adverse recommendation.
Advanced Tips for MS.01.01.01

Fair Hearing Plan - “basic steps” versus “associated details”:

• Prior to MS.01.01.01 Bylaws either contained the entire Fair Hearing Plan or there was a completely separate document.

• After MS.01.01.01, at least some of the process must be set forth in the Bylaws. However, this does not require the entire Fair Haring Plan to be in the Bylaws.

• May choose not to have full plan in the Bylaws to enable easier modification/amendment to the Plan and to make the Bylaws more manageable.
Example Language

• **Fair Hearing and Appellate Review Plan** Whenever any practitioner is entitled to a hearing as provided by these Bylaws, such hearing shall be conducted in accordance with the Hospital's Fair Hearing and Appellate Review Plan, unless these Bylaws provide otherwise.

• **Request for Hearing** Any request for a hearing must be submitted in writing to the Hospital President/CEO within thirty (30) calendar days after the practitioner receives notice of the recommendation or action which entitles the practitioner to a hearing.
Example Language

- **Hearing Committee** Hearings shall be conducted before a committee of at least three (3) impartial members of the Medical Staff, plus alternates, or before a committee of one consisting of an arbitrator mutually agreeable to the practitioner and the Hospital or a hearing officer. The procedures for selection of the Hearing Committee or an arbitrator or single hearing officer shall be set forth in the Fair Hearing and Appellate Review Plan.
Advanced Tips for MS.01.01.01

Example Language

• Hearing Officer  If the hearing is conducted before a committee of impartial members of the Medical Staff, a Hearing Officer designated in accordance with the Fair Hearing and Appellate Review Plan shall be appointed to preside over the hearing and regulate all proceedings related to the hearing. The procedures for appointment of the Hearing Officer shall be set forth in the Fair Hearing and Appellate Review Plan.
Example Language

• **Notification of Right and Obligations**  The practitioner shall be notified of the practitioner’s rights and obligations in connection with a hearing including:
  • The right to be represented by counsel,
  • The right to have a record made of the proceedings,
  • The right to call, examine and cross-examine witnesses,
  • The right to present evidence,
  • The right to submit a written statement at the end of the hearing,
  • Etc…
Advanced Tips for MS.01.01.01

Example Language

• **Hearing Procedures.** Procedures for the conduct of the hearing and post-hearing procedures shall be set forth in the Fair Hearing and Appellate Review Plan and shall include the following:
  • Notice to the practitioner of the date, time and place of the hearing provided at (30) days in advance.
  • Procedures for the recommendation of the hearing panel to be considered by the Medical Executive Committee,
  • Procedures for the practitioner to submit a written response to report of the hearing panel for consideration by the Medical Executive Committee and the Board.
Example Language

• **Appellate Review**  Practitioners shall be entitled to Appellate Review of the findings and recommendations of the hearing panel by the governing body or a committee of the governing body in accordance with procedures shall be set forth in the Fair Hearing and Appellate Review Plan.

• **Adoption and Amendment**  The Hospital's Fair Hearing Plan shall be adopted, and may be amended from time to time, by the Medical Executive Committee, subject to the approval of the Hospital Board of Directors.
Advanced Tips for MS.01.01.01

New and Improved Telemedicine Credentialing:

- TJC and CMS have streamlined their competing Telemedicine Credentialing Process.

- CMS now approves the use of distant sight credentialing. Key issues:
  - Telemedicine Credentialing Agreement between Hospital and Distant Site.
  - The hospital whose patients are receiving telemedicine has evidence of an internal review of the telemedicine practitioner’s performance at the hospital and sends to the distant site agreed upon performance information for use in the periodic appraisal of the practitioner at the distant site.
Advanced Tips for Telemedicine

Example Language

- *Telemedicine is defined as the medical diagnosis, management, evaluation, treatment or monitoring of injuries or diseases through the use of communication technology when the practitioner is not in the same geographical area as the Hospital and does not come to the Hospital. The Board will determine what clinical services may be provided through telemedicine, and the number of providers required to provide telemedicine services, after considering the recommendations of the appropriate department director, the Credentials Committee and the Medical Executive Committee.*
Advanced Tips for Telemedicine

Example Language

- Practitioners who diagnose and treat Hospital patients via telemedicine link shall be not be members of the Medical Staff but shall be privileged and credentialed in accordance with Article III, provided, however, if permitted by law, regulations and any applicable accreditation standards, the Hospital may obtain and rely on information and credentialing and privileging decisions related to the practitioner’s qualifications and competence provided by another site or organization where the practitioner is located if that site meets all requirements of CMS and appropriate accreditation agencies. The Hospital will verify directly through original sources such information as the Hospital deems appropriate.
Advanced Tips for Credentialing AHPs

Equivalent Process v. Medical Staff Process

• Recommend language that makes AHPs governed by Medical Staff Bylaws, Rules and Regulations but not members of the Medical Staff.

• Recommend Language that automatically terminates an AHP’s privileges if the sponsoring/collaborating physician’s privileges are suspended or terminated and the AHP does not secure a new sponsoring/collaborating physician in a period of time (i.e. 60 days).
Questions?

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