



SMHC MEDICAL STAFF CREDENTIALING MANUAL

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This manual contains Medical Staff policies considered associated details regarding credentialing and privileging. It supplements credentialing and privileging matters addressed in the Medical Staff Bylaws (including the Corrective Action and Fair Hearing section of those Bylaws).

PREAMBLE

Medical Staff credentialing and privileging are not the same; one can hold Medical Staff membership without clinical privileges, and qualified individuals may hold clinical privileges without being members of the Medical Staff. The process for both is the same with regard to the verification of education, training, licensure, etc., but membership and privileges are considered separately. The credentialing and privileging process is also similar to that for enrolling providers with insurance providers, but this is a separate process referred to as “payor enrollment.”

PART I: GENERAL INFORMATION

1-1 INTRODUCTION

The credentialing and privileging process involves a series of activities designed to collect, verify, and evaluate data relevant to a practitioner’s professional performance. These activities serve as the foundation for objective, evidence-based decisions regarding appointment to membership on the Medical Staff and recommendations to grant or deny initial and renewed privileges. In the course of the credentialing and privileging process, an overview of each applicant’s licensure, education, training, current competence, and physical ability to discharge patient care responsibilities is established.

1-2 GENERAL PROCEDURE

The Medical Staff, through its designated committees and officers, shall evaluate and consider each application for appointment or reappointment and/or clinical privileges, and each request for modification of staff membership or privileges, and shall adopt and transmit recommendations to the hospital Board.

1-3 ELIGIBILITY AND QUALIFICATIONS FOR MEMBERSHIP

The basic eligibility criteria and qualifications for membership on the Medical Staff of SMHC (Hospital) are found in the Medical Staff Bylaws in Article II. In addition, the Board, after requesting input from the Medical Executive Committee (MEC), may impose further requirements on specific practitioners where it believes these are warranted after a review of the practitioner’s credentials file, peer review and performance data, or other relevant material.

1-4 DURATION OF APPOINTMENT

Appointment to the staff may be for no more than 24 months.

PART II: APPLICATION PROCESS FOR APPOINTMENT, REAPPOINTMENT, AND/OR CLINICAL PRIVILEGES

2-1 APPLICATION FOR INITIAL APPOINTMENT AND/OR CLINICAL PRIVILEGES

2-1.1 Application Form

A request for application for Medical Staff membership and/or clinical privileges must be made through the hospital Medical Staff Office. If the applicant meets criteria for membership and/or privileges, the Medical Staff Office will authorize the hospital’s Credentials Verification Organization (CVO) to send an application.

The Medical Staff Office will notify the applicant by e-mail that an application and relevant privilege form (if necessary) will be sent to them directly by the CVO; this e-mail will also include a link to the Medical Staff Bylaws and Associated Manuals, and the amount of the application fee, if applicable.

The provision of, and access to, these documents may be in electronic form.

Each application for Medical Staff appointment and/or clinical privileges must be submitted on the prescribed form issued by the hospital, and signed by the applicant. The applicant must submit a current picture hospital ID card, or a valid picture ID issued by a state or federal agency (i.e., driver's license or passport).

2-2 APPLICATION FEE

If requested, a non-refundable application fee, in an amount established by the MEC, shall be payable at the time of application for appointment or reappointment. Applications submitted without the accompanying fee, if one has been requested, will not be accepted for processing.

2-3 EFFECT OF APPLICATION

By applying for Medical Staff appointment and/or clinical privileges, the applicant:

- A. Agrees to provide, in a timely fashion, any additional information and to resolve any questions relating to his/her application that are requested or posed by the Medical Staff, hospital, or Board representatives.
- B. Agrees to appear for interview(s) upon request. All applicants for appointment or reappointment to the Medical Staff and/or clinical privileges may be required to participate in an interview at the discretion of the Specialty Medical Director, the Credentials Committee, MEC, or Board. The interview may take place in person or by telephone, video, or computer link, at the discretion of the party calling for the interview. The interview will be used to gather information about the applicant and to communicate information to the applicant concerning Medical Staff responsibilities and expectations.
- C. Authorizes hospital representatives to consult with other hospitals and medical staffs who have been associated with the applicant and with anyone who may have information bearing on the applicant's clinical competence and qualifications for Medical Staff membership or privileges.
- D. Consents to the inspection by hospital representatives of all records and documents that may be material to an evaluation of the applicant's professional and ethical qualifications for staff membership.
- E. Agrees that, in the event of any adverse recommendations or decisions with respect to Medical Staff membership or privileges, as defined in these Bylaws, the applicant shall exhaust the administrative remedies afforded by these Bylaws before resorting to formal legal action.
- F. Releases from liability all individuals and organizations that provide information, including otherwise legally privileged or confidential information, to hospital representatives concerning the applicant's competence, professional ethics, character, physical and mental health, professional conduct, and other qualifications for staff appointment and clinical privileges.
- G. Signifies that the information submitted in her or her application is true to the best of his/her knowledge and belief, and that he/she understands that any significant misstatement(s) on, or omissions from, his/her application shall constitute grounds for rejection of the application. Where such omissions or misstatements are discovered after appointment to the staff, the Board, at its sole discretion, and after consultation with the MEC, may terminate the applicant's membership and privileges, and the applicant will not be eligible for the due process described in the Medical Staff Corrective Action and Fair Hearing section of the Medical Staff Bylaws.

2-4 APPLICANT'S BURDEN

The applicant shall have the burden of producing adequate information for a proper evaluation of his or her licensure, education, experience, background, training, clinical competence, and ability to

adequately perform the privileges requested, and for resolving any doubts about these or any of the qualifications specified in the Medical Staff Bylaws or in their associated manuals or policies.

The applicant must be able to demonstrate, to the satisfaction of the Credentials Committee, MEC, and Board, proficiency in the following six general competencies as described by the Accreditation Council for Graduate Medical Education (ACGME):

1. Patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life;
2. Medical/clinical knowledge of established and evolving biomedical, clinical, and social sciences, and the application of their knowledge to patient care and the education of others;
3. Practice-based learning and improvement, using scientific evidence and methods to investigate, evaluate, and improve patient care practices;
4. Interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams;
5. Professionalism, demonstrating behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society; and
6. Systems-based practice, demonstrating both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

An application for appointment or reappointment will not be processed by the Medical Staff until it is deemed complete by the hospital. If the Medical Staff Office, a Medical Staff committee, or the Board requests additional information from the applicant to evaluate his/her application, the application will be deemed incomplete until all requested information is provided. If the application remains incomplete for more than thirty days following the request for additional information by the hospital, it will be considered to have been voluntarily withdrawn by the practitioner.

2-5 CONTENT OF APPLICATION

The verification of an applicant's education and relevant training informs the organization of the applicant's clinical knowledge and skill set. The information collected includes, but is not limited to, the following, verified from the primary source wherever feasible:

- A. Current Licensure: Unrestricted Maine State license, unrestricted federal DEA, as appropriate to specialty. Licensure is primary source verified at the time of initial granting, renewal, and revision of privileges, and at the time of license expiration.
- B. National Practitioner Data Bank (NPDB): The applicant will be enrolled in NPDB continuous query.
- C. Qualifications: Detailed information concerning the applicant's qualifications, including information needed in order to satisfy the basic eligibility and qualifications of Medical Staff membership and to meet any additional qualifications necessary to be granted the privileges requested.
- D. Education and Training History: A chronological history of the applicant's undergraduate education, all graduate education in the healthcare field, and all post-graduate training (internships/residencies/fellowships) in any healthcare field. For reappointment, documentation or attestation of continuing training, education, and/or experience that qualify the applicant for the privileges requested.

- E. Current Clinical Competence: Verification from the applicant's residency program director or designee, if available. Verification of board certification or qualification for certification from the appropriate specialty board(s). Written documentation from individuals personally acquainted first-hand with the applicant's recent professional and clinical performance including, if available and applicable, types of surgical procedures performed, outcomes for invasive procedures performed, and types of medical conditions managed as the responsible physician, clinical judgment and technical skills, and professional conduct.
- F. Health Status: A health status statement provided by the hospital and signed by the applicant indicating that no physical or mental health problems exist that prevent the applicant from performing the requested clinical privileges, with or without reasonable accommodation. This document may be confirmed by the director of the applicant's training program, a chief of service or chief of staff (or equivalent) at another hospital, or a qualified physician who has examined the applicant. The applicant must meet health screening requirements as determined by the MEC for membership and/or privileges.
- G. Quality Data: Data From professional practice review by an organization that currently privileges the applicant, if available.
- H. Privileges Requested: If requesting clinical privileges, the applicant must submit the request on an approved hospital form. At the time of appointment and initial granting, renewal, and revision of clinical privileges, the hospital may require verification of relevant training or experience from the primary source(s), when feasible.
- I. Peer References: Applicants must submit the names of at least three peers (preferably from the same professional discipline as the applicant, whenever possible) who are acceptable to the Credentials Committee and MEC and who have worked with the applicant and observed his/her professional performance and who can provide comment as to the applicant's current competence, professional ability and judgment, ethical character, and ability to work cooperatively with other practitioners and hospital personnel, such that patients treated by the applicant receive quality care delivered in a professional and timely manner. Information provided by the reference should address the applicant's abilities with regard to the general competencies adopted from time to time by the American College of Graduate Medical Education (ACGME). Peer references must be submitted on a peer reference form provided by the Medical Staff Office or its CVO, and/or the reference should answer specific questions posed on this form.

Upon renewal of privileges, when insufficient practitioner-specific data are available, peer references will be obtained and evaluated.

- J. Malpractice Insurance: Evidence of continuous malpractice insurance coverage, minimum of \$1 million per occurrence/\$3 million aggregate, or in an amount that may be determined from time to time by action of the Board.
- K. Professional Sanctions: Information as to whether the applicant's membership status and/or medical staff privileges have ever been voluntarily or involuntarily revoked, suspended, reduced, subjected to restrictions or limitation not applicable to other practitioners in the same Medical Staff category, or not renewed at any other hospital, health care institution, or health plan, including whether any of the following has ever been voluntarily or involuntarily suspended, revoked or denied:

1. Membership/fellowship in a local, state, or national professional organization;
2. Staff membership status or clinical privileges at any other hospital or health care institutions;
3. Specialty board certification;
4. Licensure to practice any profession in any jurisdiction;
5. Drug Enforcement (DEA) number or a state controlled substance license; and
6. Information as to any current or pending sanctions, affecting participation in any insurance plan or federal healthcare program or any actions which might cause the practitioner to become ineligible for such programs;
7. Information regarding whether the applicant has been convicted of any type of insurance fraud, been found guilty under the False Claims Act, or is on the OIG excluded provider list for Medicare and/or Medicaid.

If any such actions were ever taken, or if any such actions are currently pending, the particulars of these actions must be included with the application.

- L. History of Medical Staff Membership: A chronological history listing all of the applicant's current and prior hospital affiliations, including applications that were withdrawn, including full addresses of the facilities at which such memberships or privileges were held.
- M. Professional Employment History: A chronological history of the applicant's entire employment history as a healthcare professional.
- N. Professional Liability Actions: All particulars regarding medical malpractice claims filed against the applicant, any adverse and/or pending malpractice decisions or settlements, and of any cancellation, non-renewal, or limitation of malpractice insurance coverage.
- O. Non-Medical Legal Actions: Information as to whether the applicant has ever been named as a defendant in any legal proceedings, regardless of the outcome, and the particulars of such proceedings.
- P. Criminal Actions: Information as to whether the applicant has ever been convicted of a felony or submitted a plea of guilty or no contents, if a felony prosecution is now pending against the applicant, and the particulars of any such conviction, settlement, or prosecution, if any.
- Q. Miscellaneous Information: Such other information relating to evaluation of the applicant's professional qualification, ethical character and professional conduct, current competence, and prior professional experience, including utilization of hospital resources, as may be deemed relevant by the MEC and the Board.

2-6 PROCESSING OF APPLICATIONS

2-6.1 Timeframe for Processing

Completed applications for Medical Staff appointment and/or privileges shall be considered in a timely and good faith manner as described in Section 8-3 of the Medical Staff Bylaws.

2-6.2 Specialty Medical Director Action

Once collection and verification is completed, the hospital shall make available the complete verified application and its supporting materials to the Specialty Medical Director for review and recommendation to the Credentials Committee.

2-6.3 Credentials Committee Action

Upon receipt of a completed application, the Credentials Committee shall review the application, its supporting documentation, and such other information available to it that may be relevant to consideration of the applicant's qualifications. The committee may also conduct a personal interview with the applicant. The Chair of the Credentials Committee may request evaluation of the application from anyone on the Medical Staff in order to obtain input from someone with needed subject matter expertise. Where necessary, the Chair may also seek such expertise from a specialist outside of the Medical Staff.

After its review of the applicant's credentials, the Credentials Committee shall submit a recommendation to the MEC. This recommendation shall address the applicant's Medical Staff membership and category, privileges, and any specific conditions relating to appointment and/or privileges. Minority views regarding any or all recommendations of the Credentials Committee may also be included.

2-6.4 Medical Executive Committee Action

Upon receipt of the report and recommendations of the Credentials Committee, the MEC shall review the applicant's request for membership and/or privileges. The MEC may utilize appropriate additional sources of information, including personal interviews with the applicant, as it deems necessary, to complete its evaluation.

After completing its review of the applicant's qualifications, the MEC shall transmit to the Board a report and recommendation regarding appointment and/or privileges for the applicant, indicating whether the applicant's requests should be accepted, accepted with modifications or qualification, or rejected. Where appointment is recommended, the MEC shall also recommend appointment to a staff category. Where the MEC recommends that the applicant's requests for membership and/or privileges be rejected, modified, qualified, or otherwise restricted, the report of the MEC shall set forth reasons for such recommendation(s). If a MEC recommendation is not unanimous, a minority report may be submitted to the Board.

2-6.5 Effect of Medical Executive Committee (MEC) Action

- A. Favorable Recommendation: When the recommendation of the MEC is favorable to the applicant, the recommendation shall be forwarded to the Board.
- B. Deferred: Any action by the MEC to defer the application for further consideration must be followed up within ninety (90) days with a subsequent recommendation.
- C. Adverse Recommendation: When the MEC recommends denial or a restriction of membership or a requested privilege, based on a determination of unprofessional conduct or inadequate clinical competence, the President of the Medical Staff shall inform the applicant by special notice within ten (10) days. The applicant shall be entitled to the procedural rights as provided in the Corrective Action and Fair Hearing section of the Medical Staff Bylaws. The Hospital President and Board shall also be notified.

2-6.6 Action of the Board

Upon receipt of the report and recommendations of the MEC regarding an application for membership and/or privileges, the Board shall consider and act on such recommendations.

- A. Favorable Recommendation: If the Board accepts a favorable MEC recommendation, it shall act to grant the requested membership and/or privileges.

When the Board decides to appoint an applicant to the Medical Staff, its decision and the notice of appointment shall include:

1. Length of appointment (for not more than 24 months);
 2. Staff category to which the applicant is appointed;
 3. Privileges the applicant may exercise; and
 4. Special conditions attached to the appointment and/or exercise of privileges, if any.
- B. Deferred: If the Board decides to defer action on the application pending further consideration by the MEC, or if the Board does not accept the recommendation of the MEC, it shall refer the application back to the MEC for further consideration, subject to the requirement that a final recommendation be provided to the Board by the MEC within ninety (90) days. At the next meeting following the receipt of the second report of the MEC, the Board shall render its final decision regarding the application.
- C. Adverse Recommendation: If the recommendation of the MEC is adverse to the applicant, as defined under the Medical Staff Bylaws, the Board shall postpone its final decision on the applicant, pending the applicant's decision to utilize or waive procedural rights. If the applicant waives his or her right to a fair hearing and appellate review, the Board will then determine its final decision on the request for membership and/or privileges. If the applicant requests a fair hearing, the Board will make a determination on the applicant's request following a final recommendation from the MEC, which takes into consideration the findings of the hearing panel. Where the applicant further requests an appellate review by the Board, its final determination will result from the decision made by the review panel.

2-7 CONFLICT RESOLUTION

Whenever the Board's proposed decision on an applicant for membership and/or privileges will be contrary to the MEC's recommendation, the Board shall submit the matter to a joint conference, as provided in Section 14-5 of the Medical Staff Bylaws. This joint conference will be held as soon as practicable and the Board will postpone any final determination on an applicant until such conference is held.

2-8 NOTICE OF FINAL DECISION

Notice of the final action of the hospital Board on an applicant shall be given to the hospital President and/or designee who will provide the applicant with a letter describing the Board's decision. The Board shall give notice of its final decision through the hospital President to the President of the Medical Staff, and the MEC.

2-9 REQUEST FOR MODIFICATION OF MEMBERSHIP STATUS

A medical staff member may, either in connection with reappointment or at any other time, request modification of staff category by submitting a written application to the hospital in such form as may be prescribed by the MEC or the Board. Such staff member shall have the burden of justifying such modification(s). Such appointments shall be processed in substantially the same manner as applications for reappointment or membership and/or privileges.

2-10 EFFECTIVE DATE OF APPOINTMENT OR MODIFICATION OF MEMBERSHIP STATUS

Appointments and reappointments approved by the Board, including privileges granted in connection with such appointments, modifications or categories of staff membership, and/or privileges, shall take effect on a date determined by the Board.

2-11 REAPPOINTMENT PROCESS

2-11.1 Application for Reappointment

Reappointment will be for **not more than 24 months**. Approximately 180 days prior to the expiration date of his/her current appointment of membership and/or privileges, the hospital and/or its approved CVO shall provide each practitioner with an updated application form for reappointment and any required hospital-specific forms and documents for completion that must be received prior to the reappointment application being acted upon. Each practitioner who desires reappointment shall, at least 90 days prior to the expiration date of his/her current membership and/or privileges, complete such forms and return them to the hospital. Failure to return the completed form(s) at least 90 days prior to his/her expiration may, at the discretion of the hospital, be considered a voluntary resignation of membership and/or clinical privileges, effective at the end of the staff member's current term.

2-11.2 Content of Reappointment Application

The requirements for the reappointment application are the same as detailed in Section 2-6; information must be updated to reflect any changes since previous appointment/reappointment.

2-11.3 Procedure for Reappointment

Refer to Sections 2-1 through 2-7.

2-12 EFFECTIVE DATE OF REAPPOINTMENT AND/OR STAFF PRIVILEGES

Reappointments approved by the Board, including privileges granted in connection with such reappointments, modifications or categories of staff membership, and/or privileges, shall take effect on a date determined by the Board.

2-13 FAST TRACK PROCESS FOR INITIAL APPLICATIONS

The Medical Staff Office has developed a process to expedite the presentation of certain initial applications to the Credentials Committee for review and recommendation between regular monthly meetings, when there is an urgent patient care need for the provider. To determine if an application is eligible for Fast Track, it must be complete and it must meet specific criteria:

1. The application is complete, with no outstanding verifications, and all requested information has been returned promptly.
2. There are no negative or questionable recommendations (i.e., ratings of "fair" or "poor" or a recommendation with reservation).
3. There are no discrepancies in information received from the applicant or from references.
4. The applicant has completed a normal education/training sequence.
5. There have been no disciplinary actions or legal sanctions.
6. There have been no malpractice cases within the past ten years.
7. The applicant has had an unremarkable medical staff/employment history.
8. The applicant has submitted a reasonable request for clinical privileges, consistent with his/her specialty, based on experience, training, and competence, and is compliance with applicable criteria and the requested privileges have been reviewed and signed by the appropriate Specialty Medical Director.
9. The applicant reports an acceptable health status.
10. The applicant has never been sanctioned by a third-party payor (e.g., Medicare, Medicaid, etc.)
11. The applicant has never been convicted of a criminal offense.
12. The applicant's history shows an ability to relate to others in a harmonious, collegial manner.

If the application meets all of the above criteria, and has been recommended for appointment and/or clinical privileges by the appropriate Specialty Medical Director, the Committee Chair will review the file, confirm eligibility for Fast Track, and sign and date the criteria review form.

Applications determined to be eligible for fast track will be then be delivered to the members of the Credentials Committee electronically for review and recommendation. Once a quorum has been achieved, the votes are tallied and, if the recommendation of the committee is unanimously in favor of appointment and clinical privileges, the applicant will be eligible for temporary privileges as described in Section 2-15 of the Medical Staff Bylaws.

Fast Track applications that do not receive unanimous recommendation by the Credentials Committee will not be eligible for temporary privileges, and will be presented at the next regular meeting.

PART III: DETERMINATION OF PRIVILEGES

Practitioners providing clinical services at the hospital shall be entitled to exercise only those privileges specifically granted to them by the Board, or emergency or disaster privileges as described in this manual.

3-1 DELINEATION OF PRIVILEGES IN GENERAL

3-1.1 Requests

Each application for appointment and/or reappointment with clinical privileges must contain a request for the specific clinical privileges desired by the applicant on an approved hospital privilege form. Practitioners who are ineligible for Medical Staff membership may apply for privileges for specific programs and/or services. A request by a practitioner for privileges or the modification of privileges must be supported by all requested documentation regarding appropriate licensure, education, training, and evidence of current competence. Privilege requests will not be processed if the applicant does not meet the eligibility requirements to be granted the privilege at SMHC.

3-1.2 Basis for Determinations of Privileges

Privileges shall be determined on the basis of the practitioner's prior and continuing education, training, experience, utilization patterns and demonstrated current competence, including observed professional performance and documented results of practitioner-specific performance improvement/peer review activities. Information concerning professional performance obtained from other sources will be considered when available, especially from other institutions or health care settings where a practitioner exercised privileges. It is the burden of the practitioner applying for privileges to provide all information requested by the Medical Staff and Board as they determine necessary to evaluate the request.

Residents or fellows in training in an ACGME-approved program, and acting under the auspices of that program, will not be required to request specific privileges.

3-1.3 Procedure

All requests for clinical privileges shall be processed pursuant to the procedures outlined in Part II. Requests for privileges will not be processed where the Board has made a determination that the hospital will not support or authorize the exercise of a particular privilege for any practitioner at the hospital, where the privilege requested is covered by an exclusive contract granted by the Board and the requesting practitioner is not a party to the contract or a provider under the contract, or where the requesting practitioner does not meet the eligibility requirements to request or exercise a privilege as described in the hospital's delineation or privileges documents.

In the event a practitioner requests a privilege for which the hospital has not adopted eligibility criteria (e.g., for a new technology or procedure), the request may be tabled for a reasonable period of time,

usually not in excess of 90 calendar days. During this time, the MEC and Board will review the community, patient, and hospital need for the privilege and determine if the institution can make available the necessary resources to adequately support the exercise of that privilege. The MEC will research appropriate eligibility criteria for the safe and effective exercise of the requested privilege and establish, with the approval of the Board, the necessary education, training, experience, and evidence of current competence that will be required to request the granted privilege. Once these steps are taken, a request for the privilege will be evaluated.

3-2 FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

The Medical staff will confirm the competence of all practitioners newly granted privileges at SMHC. This will occur following the practitioner's initial appointment of privileges and subsequently at any time a new privilege is requested for addition to the practitioners then current privileges. This activity will occur in conformance with the policy on focused professional practice evaluation adopted by the MEC. This policy will determine the manner and duration of evaluation of the practitioner's exercise of privileges and the available monitoring modalities that may be used. As a result of this initial FPPE, the Credentials Committee may recommend to the MEC and Board modifications in the privileges granted upon initial appointment.

3-3 REQUEST FOR MODIFICATION OF PRIVILEGES

A medical staff member may, either in connection with reappointment or at any other time, request modification of clinical privileges by submitting a written application to the hospital in such form as may be prescribed by the MEC or the Board. Such staff member shall have the burden of justifying such modification(s) and providing required documentation of training, experience, and current competence as required by specific privileging documents and/or at the request of the Specialty Medical Director, Credentialing Committee, MEC, and/or Board. Such requests shall be processed in substantially the same manner as applications for reappointment or membership and/or privileges. A period of FPPE may be required per the hospital's FPPE Policy currently in effect.

3-4 EMERGENCY PRIVILEGES

If the institution's Emergency Operations Plan (EOP) has been activated, and the immediate needs of patients cannot be met, selected practitioners may be granted emergency/disaster privileges to provide patient care, in accordance with statute and regulation, as described in the EOP and Bylaws Section 8-5.1.

3-4.1 Eligible Practitioners

Disaster privileges may be granted only to licensed independent practitioners (LIP) who hold a valid medical license to practice medicine or as otherwise permitted by law, and who volunteer their services, but do not hold Medical Staff privileges at SMHC.

Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the hospital will obtain valid government-issued photo identification (for example, a drivers' license or passport) and at least one of the following:

- A. A current photo identification card from a health care organization that clearly identifies professional designation;
- B. A current license to practice;
- C. Primary source verification of licensure;

- D. Identification indicated that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserves Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group;
- E. Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances;
- F. Confirmation by a licensed independent practitioner currently privileged by the hospital or by a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster;

The licensed independent practitioner (LIP) is responsible to the appropriate Clinical Section Leader who will assign the practitioner to patient care responsibilities.

Primary source verification of licensure will begin as soon as the immediate situation is under control, and completed within 72 hours from the time the volunteer physician presents to the hospital. Primary source verification applies only to volunteer practitioners who actually provide care, treatment and services while under disaster privileges. In extraordinary circumstances, in which primary source verification cannot be completed within 72 hours, it will be completed as soon as possible and reasons for the delay documented.

3-4.2 Scope of Privileges

Volunteering practitioners granted disaster privileges shall wear an approved ID at all times while volunteering at the hospital. Scope of privileges for the volunteering practitioner shall be consistent with minimum core privileges for the practitioner's specialty and as determined by the onsite supervising physician.

Within 72 hours of disaster privileges being granted, the Medical Staff leadership will make a determination of the professional practice of the volunteer practitioners utilizing direct observation, mentoring or record review and the need for continuation of the disaster privileges granted.

3-4.3 Termination of Privileges

Disaster privileges will be for the duration of the emergency situation. Privileges will automatically be canceled when it is determined by the hospital that an emergency situation no longer exists. In the event that any information received through the verification process or the professional practice review indicates adverse information suggesting the person is not capable of rendering services in an emergency, such privileges shall be immediately terminated. Practitioners granted disaster privileges will not be eligible for the due process rights afforded under the Medical Staff Bylaws, and the exercise of disaster privileges will be considered a waiver by the practitioner to any and all rights to contest or appeal the restriction or termination of such privileges.

3-5 TELEMEDICINE PRIVILEGES

3-5.1 Definitions

- A. Telemedicine: The use of electronic or other communication technology to provide or support clinical care from a distance.
- B. Originating Site: The patient location site.
- C. Distant Site: The telemedicine provider location.

3-5.2 Telemedicine Providers

Telemedicine will be provided by licensed independent and dependent practitioners who provide medical information exchanged from a distant site to SMHC via electronic communications for the health and education of the patient or health care provider, and for the purpose of improving patient care, treatment, and services. These services shall be defined in a contract with the Distant Site hospital that describes the services to be provided. These practitioners shall be privileged relying on the credentialing and privileging decision of distant site if the distant site is a Medicare participating organization, as described in Section 3-5.6 (below).

Telemedicine practitioners shall not be eligible to vote or to hold office in the Medical Staff organization; they shall not be members of the Medical Staff.

If, at any time, the contract is canceled, or if the practitioner leaves the employ of the contracted organization, or membership and privileges of the telemedicine practitioner lapse at the distant hospital, the telemedicine practitioner shall be considered to have had a voluntarily relinquishment of all clinical privileges related to telemedicine, and in the case of practitioners with privileges solely related to telemedicine, considered a voluntary relinquishment of membership and privileges. The provider will not be entitled to the procedural rights provided in these Bylaws or the Fair Hearing Plan.

3-5.3 Qualifications

To be eligible for telemedicine privileges, a practitioner must:

- A. Be a party to a contract for provision of telemedicine services;
- B. Be legally licensed to practice medicine in the State of Maine; and
- C. Have satisfactorily completed the credentialing and privileging process at the Medicare-participating hospital sponsoring the telemedicine service.

3-5.4 Prerogatives

The prerogatives of a telemedicine provider shall be to exercise such clinical privileges as are granted pursuant to the telemedicine contract;

3-5.5 Obligations

Each telemedicine provider shall:

- A. Pay dues and assessments as determined by the Medical Staff
- B. Provide care for his or her patients at the generally recognized professional level of quality and efficiency;
- C. Abide by the Medical Staff and hospital's established Bylaws, protocols, standards, policies and rules in effect at the time privileges are granted and as they may be revised from time to time.

3-5.6 Telemedicine Privileging by Proxy

In the presence of a contract with a Medicare-participating hospital for the provision of telemedicine services, the Medical Staff and Board have agreed to waive the initial and reappointment process as described in the Medical Staff Bylaws and Credentialing policies. Instead, privileges limited to the scope of service delineated in the telemedicine agreement, will be granted in reliance on the successful completion of a credentialing and privileging process at the distant hospital. If a telemedicine provider wishes to exercise additional privileges at SMHC, the usual appointment and reappointment procedures shall be followed.

3-5.7 Initial Appointment

A list of providers to be privileged will be provided by the telemedicine program. Additionally, the distant hospital will provide the medical staff with the following:

- A. Practitioner-specific information including home and business address(es), education and training, social security number, date of birth, hospital affiliations, board certification (if applicable), current hospital status, date of initial appointment, next reappointment and last reappointment (if applicable) and statement of good standing;
- B. A copy of current delineation of privileges;
- C. Copies of license, DEA (if applicable) and current insurance certificate.

The Medical Executive committee shall, at its next regular meeting after receiving the provider information, recommend to the Board the granting of privileges as delineated in the telemedicine agreement. The Board will then grant clinical privileges restricted to, and consistent with, the scope of service outlined in the telemedicine agreement.

3-5.8 Reappointment

At the time of reappointment of the telemedicine provider to the medical staff of the distant hospital, the distant hospital shall provide complete information to bring the file current on items including current license and, if applicable, DEA registration, professional liability insurance coverage and experience, other institutional affiliations, specialty Board certification status, a statement of good standing and a copy of current delineation of privileges. In making its reappointment decision, the distant hospital will consider information related to telemedicine provider's performance at SMHC.

The Medical Executive committee shall, at its next regular meeting after receiving the provider information, recommend to the Governing body the granting of privileges as delineated in the telemedicine agreement. The Board will then grant clinical privileges restricted to, and consistent with, the scope of service outlined in the telemedicine agreement.

3.5-9 Relinquishment of Telemedicine Privileges

If, at any time, the contract is canceled, or if the practitioner leaves the employ of the contracting organization, or membership and privileges of the telemedicine practitioner lapse at the distant hospital, the telemedicine practitioner shall be considered to have voluntarily relinquished all clinical privileges related to telemedicine, and in the case of practitioners with privileges solely related to telemedicine, considered a voluntary relinquishment of membership. The provider will not be entitled to the procedural rights provided in the Fair Hearing Plan.

- A. There is a written agreement between the originating site and the distant site that specifies that the governing body of the distant site is responsible for ensuring that the telemedicine services provided by its Telemedicine Professionals meet the requirements of the Medicare Conditions of Participation and the obligations of both parties.
- B. SMHC must set up a process to monitor ongoing telemedicine provider performance and report annually to distant site. This information must include, at a minimum, all adverse events at the originating hospital that resulted from telemedicine services provided by the telemedicine practitioner and all complaints the hospital has received about the telemedicine practitioner. It may also include satisfaction data from physician and other staff who interact with the telemedicine provider on such issues as: communication is courteous, clear and appropriate; provides rationale for recommendations/actions; respect demonstrated and returned; patient outcomes.

3-6 PRACTITIONERS PROVIDING CONTRACTED SERVICES

3-6.1 Medical Administrative Officers

A medical administrative officer is a practitioner engaged by the hospital in a management capacity which may also include clinical responsibilities such as direct patient care, or the proctoring of privileged practitioners. Medical administrative officers must hold Medical Staff appointment and clinical

privileges appropriate to their clinical activities and discharge Medical Staff obligations appropriate to their staff category. The terms of the officer's contract with the hospital will govern the effect of that contract's termination on the appointment and privileges of the officer. The officer will not be entitled to the procedural due process rights in the Corrective Action and Fair Hearing Manual of these Bylaws where membership and privileges are terminated as a matter of contract. The officer will be entitled to the same procedural rights as other staff members in the event of an adverse change in appointment or privileges is the result of a determination of demonstrated incompetence or unprofessional conduct.

3-6.2 Exclusive Contracts

Whenever the Board determines that certain hospital facilities or services will be staffed on an exclusive basis, it will do so under contracts (or letters of agreement) that identify which practitioners may work pursuant to the contract. Except in emergency or disaster situations, only practitioners authorized under the exclusive contract may hold privileges for the clinical services covered by the contract. Requests for such privileges from practitioners not so authorized will not be processed by the Medical Staff or Board. Practitioners not authorized under the contract who were granted privileges prior to the contract will not be allowed to exercise those privileges once an exclusive agreement is signed by the hospital. Ineligibility to exercise or request privileges covered by an exclusive contract will not entitle a practitioner to the procedural due process rights described in the Corrective Action and Fair Hearing Manual of these Bylaws.

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