Annals of Health Law

Volume 14
Issue 2 *Summer 2005*

Article 8

2005

A New Quality Challenge: Coordinating Credentialing and Corporate Compliance

Mark A. Kadzielski
Fulbright & Jaworski, LLP

A New Quality Challenge: Coordinating Credentialing and Corporate Compliance

Mark A. Kadzielski, Esq.[*]

I. NEW DEVELOPMENTS IN CENTRALIZED CREDENTIALING AND INFORMATION SHARING

The centralization of the credentialing process in post-*Darling*[1] health care systems has increased rapidly in recent years. Not only are there economies of scale to be achieved by such centralization, but the use of uniform credentialing forms, such as a single application form, will help avoid duplication and confusion. Despite the advantages of such centralization, there are a number of legal issues that arise, particularly with regard to the legal constraints governing the sharing of information by, among, and between the various health care entities that may not have similar or identical protections under state law.

There is a whole continuum of ways in which a health care organization can be involved in centralized credentialing, including the use of a centralized credentialing verification organization (CVO), common application forms, and/or joint credentialing decisions and peer review actions.[2] The sharing of application information, for example, by several health facilities within a system is a simple way to streamline the application process. However, in many health systems, the existence of different licensed entities, as well as entities which have no license or approval from a state regulatory body, creates legal exposure. For example, in a health care system which encompasses three hospitals, one Health Maintenance Organization (HMO), two ambulatory surgery centers, and a physician hospital organization, there may be several layers of legal protection based on different statutes for the information in the possession of each of those organizations, and there will be no protection for some of

---

[*]Mr. Kadzielski is the partner in charge of the West Coast Health Law Practice at Fulbright & Jaworski, L.L.P.

1. Darling v. Charleston Cmty. Mem'l Hosp., 211 N.E.2d 253 (Ill. 1965).

2. Joanne P. Hopkins & Mark A. Kadzielski, *Credentialing and "Deselection" of Providers in Health Care Delivery Systems*, 31 J. HEALTH & HOSP. L. 1, 6 (1998).

those organizations under existing and antiquated state laws (e.g., the physician hospital organization may have no protection whatsoever). Given the increased liability for managed care organizations involved in credentialing decisions, these protections take on a whole new level of importance.[3]

Notwithstanding these issues, health care delivery systems have encouraged centralized credentialing and decision-making so that some level of uniformity may be achieved. This is extraordinarily difficult, however, when each hospital has a different set of medical staff bylaws with different credentialing criteria, committee structures for making peer review decisions, and appeal rights. While many systems may pay lip-service to the concept of "one big happy family of health care providers" in their marketing approaches, standardization of the process of gathering information and making decisions in order to promote the same quality and consistency of care within the various organizations is much more difficult to achieve. Moreover, the liability exposure for a determination by one component of a health care delivery system that an individual practitioner is not competent, resulting in the termination of that practitioner's right to practice at that component, raises the specter of liability if that practitioner is permitted to thereafter exercise his or her privileges at any of the other components of the health care delivery system.[4] If, in fact, the practitioner does not concurrently lose the right to practice at the system's other components because the linkage between the peer review systems at all the components has not yet been established, there are additional liability considerations to patients who may be injured by the practitioner.[5]

While various facilities have dealt with these issues in different ways, it has been feasible to perform credentialing, quality management, and peer review functions "jointly" in certain health care organizations and maintain compliance with legal and accreditation requirements. For example, the establishment of a "joint credentialing committee" for all entities within a health care system could serve the function of ensuring uniform and common credentialing decisions. If each of these entities holds a legal protection from discovery with regard to the credentialing information they share pursuant to state peer review laws, it is reasonable that such information could be shared between entities without jeopardizing that protection.[6] Reciprocal language in medical staff bylaws for hospitals and

3. Mark A. Kadzielski, *Provider Deselection and Decapitation in a Changing Health Care Environment,* 41 ST. LOUIS U. L.J. 891, 913-14 (1997).

4. Hopkins & Kadzielksi, *supra* note 2, at 7.

5. *Id.*

6. *Id.* at 5.

ambulatory surgery centers will also accomplish this purpose. Additionally, written agreements or contracts between entities within the system assuring the protection of the peer review confidentiality will help preserve this protection.[7]

II. CREDENTIALING AND CORPORATE COMPLIANCE

Since the *Darling* decision,[8] there has been an explosion of credentialing information through new sources. They include new federal data banks, federal exclusion/debarment lists, state licensure boards, private companies, and trade associations.

A. The Advent of Patient Credentialing Creates New Liability Risks

The most significant development since *Darling*[9] has been the emergence of "patient credentialing." Presently, there are numerous Internet websites containing credentialing information on health care providers, including licensure actions, federal program debarments, and board specialty society decisions. Disgruntled patients can use their personal computers to "credential" the physicians they have just visited with a click of a mouse. The advent of this publicly available information has upset health care credentialing because consumers of health care now have equal or greater access to negative information on practitioners than health care organizations and systems do. Under these circumstances, professional organizations, like the National Association Medical Staff Services (NAMSS), and their state affiliates, have been counseled to advise their members that the days of credentialing providers once every two years for purposes of reappointment are gone. Indeed, client health care institutions and their NAMSS members have been advised to consider establishing a policy whereby they credential every practitioner on their medical staffs or managed care panels by checking certain identified websites on a regular basis, i.e., twice a year or more frequently. Having a policy that requires the credentialing of every member of the staff via certain common websites will go a long way to limit the liability for negligent credentialing which has exploded onto the health care scene due to the proliferation of publicly available negative information about practitioners. Checking these sites with some regularity will help minimize problems with credentialing providers.

Like many states which provide health care practitioner credentialing and

7. *Id.* at 5; *see id.* at 7-8 (providing sample provisions on information sharing in health care delivery systems bylaws and policies).

8. *Darling*, 211 N.E.2d at 253.

9. *Id.*

licensure information on one official centralized site, Illinois consumers interested in such information can turn to the Illinois Division of Professional Regulation website.[10] The website has been approved as a primary source for verification of health care practitioner credentials by the Joint Commission of Accreditation of Health Care Organizations (JCAHO), the National Committee on Quality Assurance (NCQA), and the American Osteopathic Association's Health Care Facilities Accreditation Program (HFAP).[11] As a verification tool, the website provides a "license look-up" search engine as well as a search engine for specific disciplinary reports regarding physicians and other practitioners in the health care field.[12] Other than the Division of Professional Regulation site, Illinois does not offer state-specific website options to check health care practitioner credentialing information.

However, for viewers interested in the credentialing information of practitioners in other states, the website for the Association of State Medical Board Executive Directors provides links to over half of the states' individual state licensing websites.[13] Several states have provided their licensing data directly to the DocFinder site and thus, viewers can access practitioner information directly from the site.[14] Illinois does not provide licensure data directly to the site but the site does have a direct link to the Illinois Department of Professional Regulation website discussed above.[15] Viewers interested in obtaining certification and credentialing information for specialists nationwide can find such information at the website of the American Board of Medical Specialties.[16] By registering on the site, an interested consumer can search the database for the credentials of specialists.[17] However, the site is not completely accepted by JCAHO or the NCQA for commercial use for verification purposes because dates are not supplied. [18] Nevertheless, information on Illinois specialists can be obtained on this site.

If a consumer is interested in checking to see whether a provider of any

10. Illinois Division of Professional Regulation website, *at* http://www.ildpr.com/licenselookup/ (last visited Feb. 22, 2005).

11. *Id.*

12. *Id.*

13. Administrators in Medicine website, *at* http://www.docboard.org (last visited Feb. 25, 2005).

14. *Id.*

15. *Id.*

16. American Board of Medical Specialties website, *at* http://www.abms.org (last visited Feb. 25, 2005).

17. *How To Obtain Board Certification Data*, *at* http://www.abms.org/bcdata.org (last visited Feb. 26, 2005).

18. *Id.*

license is excluded from participating in any federally-funded health care program, the website of the United States Office of Inspector General (OIG) is easily navigable.[19] The bases for exclusion from federally-funded programs include convictions for program-related fraud and patient abuse, licensing board actions, and default on Health Education Assistance Loans.[20] The online searchable database allows the consumer to query the name of individual practitioners or providers.[21] As of September of 2004, there were 1,208 excluded individuals and entities in Illinois, the state with the sixth highest number of exclusions in the United States.[22] Moreover, the General Services Administration (GSA) also maintains a website containing debarment actions taken by various federal agencies, including the OIG.[23]

In addition to the free resources mentioned above, there are many websites that allow viewers to research the background of health care practitioners for a small fee. Persons interested in obtaining physician disciplinary reports can visit Doc Info, a site sponsored by the Federation of State Medical Boards and advertised as a website that offers consumers instant access to a nationally consolidated database of state disciplinary data.[24] Consumers can learn if a physician has a disciplinary history by filling out a standard form online and paying a fee of $9.95 for each report.[25]

Non-trade groups also provide physician disciplinary reports for a fee. For $7.95, consumers can obtain a Physician Quality Report from Health Grades.[26] The report includes information about governmental disciplinary actions, board certification, and education and training, among other topics.[27] At ChoiceTrust, a Credential History Report for health care

19. U.S. Office of Inspector General website, *at* http://www.oig.hhs.gov/fraud/exclusions.html (last visited Feb. 18, 2005).

20. *About the OIG Exclusion Program*, *at* http://www.oig.hhs.gov/fraud/exclusions/aboutexclusions.html (last visited Feb. 26, 2005).

21. *List of Excluded Individuals/Entities Search*, HHS Office of Inspector General, *at* http://www.exclusions.oig.hhs.gov/search.html (last visited Feb. 26, 2005). The search page also contains links to cumulative exclusions data segregated into three areas: by state, general classification, and exclusion type.

22. *Id.*

23. Excluded Parties List System website, *at* http://www.epls.arnet.org (last visited Feb. 18, 2005).

24. DocInfo website, *at* http://www.docinfo.org (last visited Feb. 26, 2005).

25. DocInfo Search Page, *at* http://www.docinfo.org/alp_data_entry.htm (last visited Feb. 26, 2005).

26. *Help at HealthGrades*, *at* http://www.healthgrades.com/consumer/index.cfm?fuseaction=mod&modtype=content&modact=hg_help (last visited Feb. 26, 2005).

27. HealthGrades website, *at* http://www.healthgrades.com/consumer/index.cfm?fuseaction=mod&modtype=PRC&TV_Eng=homepage_drop (last visited Feb. 26, 2005).

providers can be purchased for $9.95.[28]

Websites that do not provide extensive or specific information on the credentials of health care practitioners, but instead address accreditation more generally, are also useful for consumers. JCAHO evaluates the quality and safety of care for more than 15,000 health care organizations nationwide.[29] In order to maintain JCAHO accreditation, health care organizations must go through an extensive on-site review with JCAHO staff every few years.[30] Accreditation is given based upon the organization's ability to meet JCAHO standards.[31] Consumers can access JCAHO accredited organizations and can view the survey results under the "Quality Check" section of the website.[32]

If consumers are interested in the accreditation of the training program their physician attended, the American Medical Association maintains a database.[33] The database includes "over 7,800 graduate medical education programs accredited by the Accreditation Council for Graduate Medical Education, as well as over 200 combined specialty programs."[34] Besides searching for specialty and subspecialty programs, interested persons can also search for training institutions, medical schools, aggregate training statistics by specialty, and career plans of recent graduates.[35]

All of these websites allow consumers to obtain credentialing information on health care practitioners in Illinois and nationwide. As such, these websites are useful for health care organizations to help minimize problems with credentialing providers and to keep pace with patients who can and do "credential" immediately before or after receiving care.

B. The National Practitioner Data Bank

The National Practitioner Data Bank (NPDB) was established by the Health Care Quality Improvement Act of 1986.[36] The NPDB has been open since September 1, 1990, and for the last fourteen years has collected

28. *Price List*, *at* http://www.choicetrust.com/servlet/com.kx.cs.servlets.CsServlet?channel=welcome&subchannel=pricelist (last visited Feb. 26, 2005).

29. *Facts About the Joint Commission on Accreditation of Healthcare Organizations*, *at* http://www.jcaho.org/about+us/index.htm (last visited Feb. 26, 2005).

30. *Id.*

31. *Id.*

32. *Quality Check*, *at* http://www.jcaho.org/quality+check/welcome.htm (last visited Feb. 26, 2005).

33. Fellowship and Residency Electronic Interactive Database, *at* http://ama-assn.org/ama/pub/category/2997.html (last updated Dec. 15, 2004).

34. *Id.*

35. *Id.*

36. *NPDB Timeline*, *at* http://www.npdb-hipdb.com/timeline.html (last visited Feb. 26, 2005).

information on various health care professionals, primarily physicians and dentists, in connection with adverse licensure, clinical privileging, professional society, and malpractice actions.[37] As of March of 2005, the NPDB contained 369,398 total reports.[38]

C. The Healthcare Integrity and Protection Data Bank

The Healthcare Integrity and Protection Data Bank (HIPDB) became available in 2000 as an integral part of the overall government crackdown on health care fraud and abuse.[39] The HIPDB is, in many respects, a more refined version of the NPDB. Created by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)[40], the HIPDB contains adverse action information on all health care providers, suppliers and practitioners.[41] As of August of 2004, the HIPDB contained 141,460 total reports.[42]

The HIPDB is a flagging system of health care fraud and abuse data collected in one location for certain final adverse actions taken against health care providers, suppliers, and practitioners.[43] Critically, and ironically, information reported to the HIPDB is available to federal and state government agencies and health plans, but not to acute care hospitals, except by self query for those acute care hospitals which may find themselves reported to the HIPDB.[44] Required to report to the HIPDB are health plans, government agencies (including the Department of Justice, the Department of Health and Human Services, and any other federal agencies that administer or provide payment for the delivery of health care services), state law enforcement agencies, state Medicaid fraud control units, and federal and state agencies responsible for the licensing and certification of health care providers and licensed health care practitioners (e.g., state medical boards).[45]

---

37. *Id.*

38. NPDB Summary Report, *at* http://www.npdb-hipdb.com/pubs/stats/npdb.summary_report.pdf (last visited Mar. 17, 2005).

39. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH RESOURCES AND SERVICES ADMINISTRATION, FACT SHEET ON THE HEALTHCARE INTEGRITY AND PROTECTION DATA BANK 1 (2003) [hereinafter HIPDB FACT SHEET], *available at* http://www.npdb-hipdb.com/pubs/fs/Fact_Sheet_Healthcare_Industry_and_Protection_Data_Bank.pdf (Nov. 3, 2003).

40. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 § 221(a), 110 Stat. 1936 (1996).

41. HIPDB FACT SHEET, *supra* note 39 at 1.

42. HIPDB Summary Report, *at* http://www.npdb-hipdb.com/pubs/stats/HIPDB_State_Agency_and_Health_Plan_Individual_Subject_Summary_Report.pdf (Mar. 17, 2005).

43. HIPDB FACT SHEET, *supra* note 39 at 1.

44. *Id.* at 2.

45. *Id.* at 2-3.

The HIPDB is very similar to its older sibling, the NPDB. The Secretary of the Department of Health and Human Services (HHS) maintains the HIPDB under the auspices of the same HHS department, the Health Resources and Services Administration, Bureau of Health Professions. In fact, the HIPDB is coordinated with the NPDB; queries submitted to the HIPDB by health plans will be processed by both the HIPDB and the NPDB and responses from both entities will be provided.[46] In addition, state licensing board actions reported to the NPDB prior to the enactment of HIPAA (i.e., as of August 21, 1996) are not in the HIPDB, but state licensing board actions reported to the NPDB effective on or after enactment are contained in both the NPDB and the HIPDB.[47]

D. What Is Included In the HIPDB

There are five types of final adverse actions which must be reported to the HIPDB:[48]

> (1) Civil judgments against a health care provider, supplier, or practitioner in federal or state court related to the delivery of a health care item or service;
>
> (2) Federal or state criminal convictions against a health care provider, supplier, or practitioner related to the delivery of a health care item or service;
>
> (3) Actions by federal or state agencies responsible for the licensing and certification of health care providers, suppliers, or practitioners;
>
> (4) Exclusion of a health care provider, supplier, or practitioner from participation in a federal or state health care program; and
>
> (5) Any other adjudicated action or decision that the Secretary of HHS establishes by regulation.

Final adverse actions against providers, suppliers, or practitioners are required to be reported regardless of whether they are being appealed by the

46. U.S. DEP'T. OF HEALTH AND HUMAN SERVICES, HEALTH RESOURCES AND SERVICES ADMINISTRATION, FACT SHEET ON THE NATIONAL PRACTITIONER DATA BANK 4 (2001) [hereinafter NPDB FACT SHEET], *available at* http://www.npdb-hipdb.com/pubs/fs/Fact_Sheet_National_Practitioner_Data_Bank.pdf (Oct. 11, 2001).

47. *Id.*

48. HIPDB FACT SHEET, *supra* note 39 at 1.

subject of the report.[49] Significantly, civil settlements are not reportable, and only federal and state agencies and health plans, but not hospitals, are permitted to query the HIPDB.[50]

The HIPDB public website encourages eligible health plans to query, in no-nonsense language:

> Eligible for the HIPDB and Haven't Queried? See the Criminal Convictions You May Have Missed.
>
> Practitioners involved in health care fraud and abuse can cost your organization millions of dollars, in addition to injuring patients. That's why querying the Health care Integrity and Protection Data Bank (HIPDB) is so important. The HIPDB is a flagging system that identifies health care practitioners, providers, and suppliers involved in health care fraud and abuse. Report information contained in the HIPDB alerts your organization to practitioners who should be more closely investigated, including those who could potentially cause major problems within your organization.[51]

In addition, NPDB and HIPDB representatives have made frequent public speeches on the usefulness of their data.[52]

E. Some Key Problems

The HIPDB is problematic because acute care hospitals are excluded from accessing its information.[53] Since the NPDB, acute care hospitals have been the front line of defense with regard to reporting information regarding corrective actions against practitioners, and using said information from the NPDB in the peer review and credentialing process.[54] With the HIPDB, the flow of credentialing information is reversed, and health plans are on the frontline.

In the past, managed care organizations had often "piggybacked" on the credentialing and membership standards of acute care hospitals, relying on

---

49. 42 U.S.C. § 1320a-7c (2005).

50. HIPDB FACT SHEET, *supra* note 39 at 2-3.

51. National Practitioner Data Bank Healthcare Integrity and Protection Data Bank website, *at* http://www.npdb-hipdb.com/ (last visited Feb. 26, 2005).

52. U.S. DEP'T. OF HEALTH AND HUMAN SERVICES, HEALTH RESOURCES AND SERVICES ADMINISTRATION, NPDB-HIPDB DATA BANK NEWS 1 (Oct. 2004) [hereinafter DATA BANK NEWS], *available at* http://www.npdb-hipdb.com/pubs/newsletter/October_2004_Newsletter.pdf.

53. 45 C.F.R. § 61.12 (2005) (detailing who may have access to the HIPDB and the fact that hospitals are not included in the list).

54. 45 C.F.R. § 60.10 (2005).

the hospitals themselves to properly credential physicians and other health care professionals.[55] Moreover, in the explosion of managed care contracting that has occurred throughout this country, much of managed care credentialing, including NPDB checks, has been conducted by medical groups, IPAs, and others who have been "delegated" or "sub-delegated" by the managed care organization to obtain this information.[56] Through HIPAA and the HIPDB, Congress, and now the OIG, are clearly holding health plans responsible for obtaining such information from the HIPDB directly.[57] This new accountability of managed care organizations will, in turn, create more liability exposure at the managed care level for credentialing practitioners with adverse HIPDB reports.

Managed care organizations may be getting requests from acute care hospitals that are not entitled to obtain information on members of their medical staffs.[58] As a result, managed care organizations need to have legally sound information sharing agreements with hospitals, and will need to make tougher decisions regarding provider contracting and credentialing.[59]

III. COORDINATING, CREDENTIALING AND CORPORATE COMPLIANCE: AN IMPORTANT CHALLENGE

For health care providers in an era of corporate compliance, information is critically important. In general, health care compliance programs have been uniformly unable to clearly and consistently address practitioner credentialing issues, particularly regarding how to handle practitioners who do not participate in Medicare, or who have civil judgments or sanctions against them. Hospitals unable to access the Healthcare Integrity and Protection Data Bank (HIPDB) information promptly and directly are nonetheless held to a high corporate compliance standard, and remain at risk for negligent credentialing.[60]

---

55. Such negligence is no longer the case as managed care plans now carry out independent credentialing or use an accredited credentialing verification entity. *See* Jerry S. Sobelman, "Managed Care Credentialing of Physicians," available at http://www.physiciansnews.com/business/601sobelman.html (last visited May 17, 2005), *see also,* Mark A. Kadzielski et al., "Credentialing in Managed Care: The New Frontier," 19 WHITTIER L. REV. 83 (Fall 1997).

56. For information on credentialing verficiation organizations, *see* http://www.ncqa.org (last visited May 17, 2005).

57. 45 C.F.R. § 61.12 (2005).

58. *Id.* Under the regulations, hospitals are not allowed to access HIPDB.

59. DANIEL F. SHAY, COMMENCE IN PROVIDER DATA: WHAT, WHY AND PROVIDER CONTRACTUAL CONTROLS, (Alice Gasfield ed., Health Law Handbook West) (forthcoming 2005).

60. Beth Anne Jackson, "OIG Work Plan for 2002 Targets Hospital Privileging:

This difficult situation is compounded by the United States Office of the Inspector General's (OIG) enforcement of Section 4304(a) of the Balanced Budget Act of 1997[61], which provides that civil monetary penalties may be imposed on "[a]ny person . . . that arranges or contracts (by employment or otherwise) with an individual or entity that the person knows or should have known is excluded from participation in a Federal health care program."[62] In such situations, hospitals and all other health care providers have both compliance and credentialing issues to overcome.

A key phrase in health care parlance has been, is, and will be, "corporate compliance." Negative information on practitioners, particularly related to fraud and abuse activities, is now immediately available on the Internet, and to health plans through the HIPDB. Under these circumstances, a dilemma is presented to health care organizations. How do you tout zero tolerance for fraud and abuse while allowing, within your midst, practitioners who have felony convictions, debarments, civil judgments, and other licensure actions, whether pending or complete, related to health care fraud and abuse?

The credentialing processes used by health care organizations now, more than ever, must take into account all information available concerning a practitioner, not just education, training and current clinical competence. Negative information regarding judgments, settlements, and licensure actions in connection with fraud and abuse must be put into the credentialing process so that information can be used to make decisions regarding health care practitioners. Zero tolerance for fraud does not necessarily mean that health care practitioners with "problems" must be expelled from health care organizations, but it does mean that, more than ever before, health care organizations must vigilantly perform more risk assessments since they will be exposed to "negligent credentialing" liability.

Revisiting the Issue of Excluded Physicians on the Medical Staff," *available at* http://images.jw.com/com/publications/30.pdf (last visited May 17, 2005).

61. Balanced Budget Act of 1997, Pub. L. No. 105-33, 4302, 111 Stat. 251, 383 (codified as amended at 42 U.S.C. § 1320a-7a) (1997).

62. 42 U.S.C. § 1320a-7a(6) (2000).