



MACOMB

**MEDICAL STAFF**  
**CREDENTIALING MANUAL**

**MOUNT CLEMENS REGIONAL MEDICAL CENTER  
CREDENTIALING MANUAL  
TABLE OF CONTENTS**

<b>I. PROCEDURES FOR APPOINTMENT.....</b>	<b>4</b>
1. GENERAL PROCEDURE.....	4
2. APPLICATION FOR INITIAL APPOINTMENT.....	4
2.1 Application Form	
2.2 Content	
3. EFFECT OF APPLICATION.....	4
4. PROCESSING THE APPLICATION.....	5
4.1 Applicant’s Burden	
4.2 Transmittal for Evaluation	
4.3 Complete Application	
4.4 Appointment Process .....	6
4.5 Staff Executive Committee Action	
4.6 Effect of Staff Executive Committee Action.....	7
4.7 Board Action	
4.8 Conflict Resolution	
4.9 Notice of Final Decision	
 INITIAL FLOW SHEET / PROCESS OF AN APPLICATION.....	 9
Medical Staff Credentialing Process Flow Chart (per Governance Manual)	
 <b>II. PROCEDURES FOR REAPPOINTMENT .....</b>	 <b>10</b>
1. REAPPOINTMENT PROCESS.....	
1.1 Information Form for Reappointment	
1.2 Verification of Information	
1.3 Final Processing and Board Action	
1.4 Bases for Recommendations	
1.5 Time Periods for Processing.....	
 2. REQUESTS FOR MODIFICATION OF TERMS OF APPOINTMENT.....	 12
 3.. BOARD APPLIED CRITERIA.....	 12

**Note:** McLaren Macomb was formerly known as Mount Clemens Regional Medical Center, prior to Jan 2012

<b>III. DETERMINATION OF CLINICAL PRIVILEGES.....</b>	<b>13</b>
<b>1. EXERCISE OF PRIVILEGES.....</b>	
<b>2. DELINEATION OF PRIVILEGES IN GENERAL.....</b>	
2.1 Request	
2.2 Bases for Privileges Determination	
2.3 Surgical Privileges/Invasive	
4 Special Conditions for Podiatric Privileges	
2.5 Procedure	
<b>3. VOLUNTARY REQLINQUISHMENT OF PRIVILEGES.....</b>	<b>14</b>
<b>4. ALLIED HEALTH PROFESSIONALS.....</b>	<b>15</b>
<i>(see new AHP Policy Manual 01 /2007)</i>	
<b>4.1 Special Conditions for Dental Privileges</b>	<b>15</b>
<b>5. TEMPORARY PRIVILEGES.....</b>	<b>15</b>
<b>5.1 Circumstances</b>	
Pendency of Application / Interim Appointment	
Care of Specific Patients	
Locum Tenens	
<b>5.2 Conditions</b>	
<b>5.3 Termination</b>	
<b>5.4 Rights of the Practitioner</b>	
<b>6 EMERGENCY PRIVILEGES.....</b>	<b>16</b>
<b>6.1 Definition of Emergency Privileges</b>	
<b>6.2 Emergency Disaster Privileges</b>	

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APPENDIX A-1 Ongoing Monitoring of Sanctions / Complaints (Delegated Credentialing Responsibilities)	(2015)
APPENDIX A-2 References for Sources to Primary Verification for Provider Applications (Required & Non-Required)	(2007)
APPENDIX B. Credentialing Policy re: New / Unusual Procedures or New Technology	(2009)

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# **I. PROCEDURES FOR APPOINTMENT**

## **1. GENERAL PROCEDURE**

The Medical Staff through its designated departments, committees, and officers shall investigate and consider each application for appointment or reappointment to the staff and each request for modification of staff membership status and shall adopt and transmit recommendations thereof to the Board. (Neither the Staff nor its committees are empowered to make any final decisions respecting appointments or privileges; such decisions are the sole responsibility of the Board.)

## **2. APPLICATION FOR INITIAL APPOINTMENT**

### 2-1 Application Form

Each application for appointment to the staff shall be typed and signed by the applicant.

### 2-2 Content

The application form shall include such provisions as are necessary to secure additional information necessary for evaluation of the applicant. In addition the form shall include a statement that the applicant has been furnished a copy of the Bylaws, Rules and Regulations of the staff, and that he agrees to be bound by the terms thereof during the time the application is under consideration and, if staff appointment is granted, while a member of the staff.

## **3. EFFECT OF APPLICATION**

By applying for appointment to the staff, the applicant:

- A. Signifies his willingness to appear for interviews in regard to his application,
- B. Authorizes hospital representatives to consult with others who have been associated with him and/or who may have information bearing on his competence and qualifications,
- C. Consents to the inspection by Medical Staff representatives of all records and documents that may be material to an evaluation of his personal and professional qualifications and ability to carry out the clinical privileges he request as well as of his ethical qualifications for staff membership,
- D. Releases from any liability all hospital representatives for their acts performed in good faith and without malice in connection with evaluating the applicant and his credentials,
- E. Releases from all liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to hospital representatives in good faith and without malice concerning the applicant's ability, professional ethics, character, physical and mental health, emotional stability, and other qualifications for staff appointment and clinical privileges.

## 4. PROCESSING THE APPLICATION

### 4-1 Applicant's Burden

The applicant shall have the burden of producing adequate information for a proper evaluation of his experience, background, training, demonstrated ability, character and professional ethics; and upon request of the Staff Executive Committee or of the Board, physical and mental status, and of resolving any doubts about these or any of the other basic qualifications specified in Sections 3.2-1 of the Medical Staff Bylaws.

The practitioner will be notified, in writing, if information obtained during the credentialing review process varies substantially from information provided by the practitioner. The practitioner will be provided an opportunity to review such information, unless legally prohibited, and correct or explain erroneous information within the time frame as specified in the notification. All corrections or clarifications must be provided, in writing to the Chief Medical Officer, and will be transmitted with the application for review by the Credentials Committee.

### 4-2 Transmittal for Evaluation

The applicant shall deliver his application form to the Chief Medical Officer, who shall, after determining that the application is complete and all pertinent materials have been secured, transmit in a timely fashion a copy of the completed application form and all supporting materials to the Credentials Committee

Upon request, practitioners will be informed of the status of their application (verbal and/or written communications will be documented in the credentials file).

### 4-3 Complete Application

Only a completed application for Medical Staff membership qualified for consideration. A completed application for Medical Staff membership must include all of the information requested on the application form with particular attention to the following:

- A. A detailed, complete description and confirmation of the education, training and practice affiliations of the applicant, accounting for all periods of time from the graduation from osteopathic college or medical school or other comparable undergraduate program depending on the specialty as to an Allied Health Professional.
- B. Letters of assessment from the required number of references who can provide meaningful reference pertaining to professional competence, ethical character, and ability to perform privileges requested.
- C. A demonstration of the manner in which the applicant meets any specific specialty training and experience requirements for particular requested clinical privileges,
- D. Confirmation that the applicant possesses the required State licensure and any required Federal registration or certification,
- E. A detailed description of any proposed or implemented restriction of denial of licensure or governmental certification or registration,
- F. A description of the professional liability insurance coverage maintained by the applicant,
- G. A detailed description of any professional liability suits or claims,

- H. A detailed description of any proposed or implemented restrictions or denials of privileges or membership at other facilities,
- I. Detailed responses to any request for information needed to clarify or supplement matters presented in the application form
- I. Information obtained from the National Practitioner Data Bank (NPDB), Office of Inspector General (OIG)/General Services Administration (GSA) and other Federal Sources.
- J. Criminal History information, and/or acknowledgment of lack of criminal convictions.

An application which is not complete shall not qualify for a credentialing recommendation. If the applicant fails to complete the application after a reasonable opportunity (i.e. 60 days), it will be deemed to have been withdrawn by the applicant. Termination of the credentialing process shall not entitle the applicant to review or appeal pursuant to the Medical Staff Bylaws. Should the application be deemed complete, the appointment process will continue.

#### 4-4 Appointment Process

Within sixty (60) days after receipt of the completed application for membership, the Credentials Committee shall make a written report of its investigation to the Staff Executive Committee. Prior to making this report, the Credentials Committee shall examine the evidence pertaining to the character, qualifications and ethical standing of the practitioner and shall determine through the information contained in references given by the practitioner and from other sources available to the committee, including an appraisal from the clinical department chairman in which his privileges are sought, whether the practitioner has established and meets all of the necessary qualifications for the category of staff membership and the clinical privileges requested by the applicant. Every department in which the practitioner seeks clinical privileges shall provide the Credentials Committee with specific, written recommendations for delineating the practitioner's clinical privileges, and these recommendations shall be made a part of the report. Together with its report the Credentials Committee shall transmit to the Staff Executive Committee through the Chief Medical Officer, or in the Chief Medical Officer absence the Chief of Staff, the completed application and a recommendation that the practitioner be either provisionally appointed to the Medical Staff or rejected for Medical Staff membership or that the application be deferred for further consideration. Any minority views of the Credentials Committee should be transmitted to the Staff Executive Committee and included in its report to the governing body.

#### 4-5 Staff Executive Committee Action

At its next regular meeting after receipt of the Credentials Committee report and recommendations, the Staff Executive Committee shall consider the report and such other relevant information as is available to it. The committee shall then forward to the Chief Medical Officer for transmittal to the Board a written report and recommendations as to staff appointment and, if appointment is recommended, as to staff category, department/division affiliations, clinical privileges to be granted, and any special conditions to be attached to appointment. The committee may also defer action on the application pursuant to Section 4-6 A. The reasons for each recommendation shall be stated and supported by reference to the completed application and all other documentation considered by the committee, all of which shall be transmitted with the report. Any minority views shall also be reduced to writing, supported by reasons and references, and transmitted with the majority report.

#### 4-6 Effect of Staff Executive Committee Action

- A. Deferral: Action by the Staff Executive Committee to defer the application for further consideration must, within thirty (30) days, be followed by a subsequent recommendation for appointment with specified clinical privileges, or for rejection of staff membership;
- B. Favorable Recommendation: When the recommendation of the Staff Executive Committee is favorable to the applicant, the Vice President, Medical Affairs shall forward within thirty (30) days the recommendation, together with the application form and its accompanying information and the reports and recommendations of the department(s) to the Board.
- C. Adverse Recommendation: When the recommendation of the Staff Executive Committee is adverse to the applicant, the Vice President, Medical Affairs shall so inform the applicant within five (5) days by special notice, and he shall be entitled to the procedural rights as provided in Article VIII of the Medical Staff Bylaws and the Fair Hearing Plan for the purpose of this Section 4-6 C, an "adverse recommendation" by the Staff Executive Committee is as defined in Sections 1-1 and 1-2, of the Fair Hearing Plan, except that in the circumstance in which the applicant accepts the limitation, reduction or denial which otherwise is deemed adverse, such acceptance converts the adverse recommendation to a favorable recommendation.

#### 4-7 Board Action

- A. On Favorable Staff Executive Committee Recommendation: The Board shall adopt or reject, in whole or in part, a favorable recommendation of the Staff Executive Committee, or refer the recommendation back to the Staff Executive Committee for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation shall be made. If the Board's action is adverse to the applicant as defined in Sections 1-1 and 1-2, of the Fair Hearing Plan, the Vice President, Medical Affairs shall so inform the applicant within five (5) days by special notice, and he shall be entitled to the procedural rights as provided in Article VIII.
- B. Without Benefit of SEC Recommendation: If the Board does not receive a Staff Executive Committee recommendation within sixty (60) days of the receipt by it of the Credentials Committee report, or if the applicant so requests, the Board may take action on its own initiative. If such action is favorable, it shall become effective as the final decision of the Board. If such action is adverse, as defined in Sections 1-1 and 1-2, of the Fair Hearing Plan, the Vice President, Medical Affairs shall so inform the applicant with five (5) days by special notice and he shall be entitled to the procedural rights as provided in Article VIII and the Fair Hearing Plan.

- C. After Procedural Rights: In the case of an adverse Staff Executive Committee recommendation pursuant to Section 4-6C or an adverse Board decision pursuant to Section 4-7 A or B, the Board shall take final action in the matter only after the applicant has exhausted or has waived his procedural rights as provided in Article VIII and the Fair Hearing Plan action thus taken shall be the conclusive decision of the Board, except that the Board may defer its final determination by referring the matter back to the Staff Executive Committee for further reconsideration. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Board shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. After receipt of such subsequent recommendation and of new evidence in the matter, if any, the Board shall make a final decision either to appoint the applicant to the Medical Staff or to reject him for staff membership.

#### 4-8 Conflict Resolution

When the Board's proposed decision will be contrary to the Staff Executive Committee's last recommendation, the Board shall submit the matter to the Joint Conference Committee for review and recommendation as provided in Sections 7-1 and 7-2 of the Fair Hearing Plan before making its final decision and given notice of final decision. In any case, in which the Hospital's legal counsel so advises, the practitioner may be invited to the meeting of the Joint Conference Committee in order to respond to any questions that may be presented to him.

#### 4-9 Notice of Final Decision

- A. Notice of the Board's final decision shall be given to the Chief of Staff, the Chairman of each department concerned, and to the applicant within sixty (60) days of the final decision.
- B. A decision and notice to appoint shall include:
  - 1. The staff category to which the applicant is appointed,
  - 2. The department (division) to which he is assigned,
  - 3. The clinical privileges he may exercise, and
  - 4. Any special conditions attached to the appointment.
- 5. A decision and notice to deny shall include reasons for denials

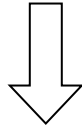


## INITIAL FLOW SHEET

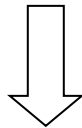
### PROCESS FOR APPLICATION FOR MEDICAL STAFF MEMBERSHIP

All request MUST be in writing

- Supporting Documents & Validation Obtained by Medical Staff Services Professionals

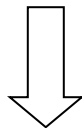


- Department Chairman provides recommendation for specific clinical privileges
  - *may request additional information*
  - *may request interview with applicant*

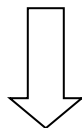


*Any adverse or unusual comments will be communicated Credentials Committee Chairman and Chief Medical Officer for specific investigation.*

- CREDENTIALS COMMITTEE reviews COMPLETE application and provides recommendation to the Staff Executive Committee (within 60 days)
  - *may request additional information*
  - *may request interview with applicant*



- Staff Executive Committee recommendation (within 60 days)  
(*IF Adverse Recommendation → defer to Hearing as outlined within Fair Hearing Plan*)



- Board of Trustees Decision (within 60 days)  
(*IF Adverse Decision → defer to Appeal as outlined within the Fair Hearing Plan*)

*(Decision by the Board of Trustees contrary to SEC - refer to Joint Conference Committee for recommendation back to Board of Trustees)*

## **II. PROCEDURES FOR REAPPOINTMENT**

### **1 . REAPPOINTMENT PROCESS**

#### 1-1 Information Form for Reappointment

The Vice President, Medical Affairs shall at least one hundred twenty (120) days prior to the expiration date of the present staff appointment of each staff member, provide such staff member with a staff membership renewal form for use in considering reappointment. Each staff member who desires reappointment shall, at least ninety (90) days prior to such expiration date, send the staff membership renewal form to the Vice President, Medical Affairs. Failure, without good cause, to so return the form shall constitute a resignation of staff membership effective at the expiration of the member's current term, without entitlement to the procedural rights provided in Article VIII and the Fair Hearing Plan.

#### 1-2 Verification of Information

The Vice President, Medical Affairs shall, in timely fashion, transmit the reappointment form to the Credentials Committee. The Credentials Committee shall seek to collect or verify the additional information made available on each reapplication and to collect any other materials or information deemed pertinent. The Credentials Committee after reviewing each reapplication and all other relevant information available to it, shall forward to the Staff Executive Committee its report and recommendation that the appointment be either renewed, renewed with modified staff category, department (division) affiliation, and/or clinical privileges, or terminated. The committee may also defer action. Each such report shall satisfy the requirements of Section 1-4. Any minority views shall also be reduced to writing and transmitted with the majority report.

#### 1-3 Final Processing and Board Action

Thereafter, the procedure provided in 4-6 through 4-9, in the Section "Procedures for Appointment", shall be followed. For purposes of reappointment, the terms "applicant" and "appointment" as used in those sections shall be read, respectively as "staff member" and "reappointment."

#### 1-4 Bases for Recommendations

Each recommendation concerning the reappointment of a staff member and the clinical privileges to be granted upon reappointment shall be based upon evaluation of:

- A. Information submitted in writing by the Staff member or allied health professional
- B. Character and ethical standing
- C. Mental and physical health
- D. Demonstrated current professional competence and judgment
- E. Recommendation from the Chiefs of departments, (divisions)

- F. Additional training and experience, and/or documentation of clinical activity to support a request to expand or limit privileges.

Such documentation may also include various certifications, i.e. CPR, ACLS, ATLS, NR , training of specific devices as required by clinical manufacturer.

- G. Specialty board certification

1. Board Certification must be obtained within requisite number of years as identified by the specialty Board,
2. Subspecialty certification is required for those individuals practicing in subspecialties, (this also extends to "Certificates of Added Qualifications" in those areas where no subspecialty certificate exists),
3. Physicians will be required to maintain certification (recertification) if required by that specialty board,
4. All current members of the Professional Staff (as of 12/1/00) may be "grandfathered" which is defined as exempt from fulfilling these new requirements in order to meet continued membership criteria at the time of adoption of this requirement,

- H. Validated quality assessment review, utilization review and other professional practice review records and compliance with Hospital and quality assurance and utilization review requirements and with all third party reimbursement documentation requirements.

- I. Professional liability and risk management history, including claims

- J. Adequacy of medical records

- K. Attendance at, general, departmental (divisional) Medical Staff meetings and Medical Staff Committee meetings

- L. Compliance with the Medical Staff Bylaws, with the Rules and Regulations of the Medical Staff, and with established Hospital standards, policies and rules

- M. Cooperation with and promotion of harmonious relationships between Medical Staff Members, Administration and employees of the Hospital, including open communication and responsiveness

- N. Changes in membership status or privileges in any other health organization and the reasons for such changes

- O. Institution of disciplinary action in any other hospital, health care or medical organization or of any action affecting licensure, certification or good standing for reimbursement purposed in any governmental agency or public or private third party payor

- P. Information obtained from the National Practitioner Data Bank (NPDB), Office of Inspector General (OIG)/General Services Administration (GSA) and other Federal Sources.

- Q. Documentation of completion of Continuing Medical Education (CME) during last biennium
- R. Criminal history information, and/or attestation to lack thereof.

#### 1-5 Time Periods for Processing

Transmittal of the reappointment form to a staff member and his return of it shall be carried out in accordance with Section II.1-1. Thereafter, except for good cause, all actions by the Credentials Committee, Staff Executive Committee and the Board shall be completed prior to the expiration date of the staff membership of the member being considered for reappointment.

If the processing of a reappointment has not been completed by the date of the expiration of the staff member's current appointment, such appointment shall remain in effect until such processing has been completed and a final decision made by the Board.

However, if the staff member is under suspension or a restriction of privileges previously imposed, such suspension or restriction shall continue in effect until such processing has been completed and a final decision made by the Board.

## **2. REQUESTS FOR MODIFICATION OF TERMS OF APPOINTMENT**

A staff member may, either in connection with reappointment or at any other time, request modification of his staff category, department (and/or division) assignment, or clinical privileges by submitting a written request to the Vice President, Medical Affairs. Such request shall be processed in substantially the same manner as provided in Procedures for Reappointment (1-5).

## **3. BOARD APPLIED CRITERIA**

The Board shall apply, in making its decisions in respect to appointments, reappointments, clinical privileges and modifications of appointments, the criteria stated in these Bylaws and, in addition, shall consider the adequacy of the hospital's facilities and supportive services needed by the practitioner for rendering care to his patients, and the need for additional practitioners with the skill and qualifications of the practitioner.

### **III. DETERMINATION OF CLINICAL PRIVILEGES**

#### **1. EXERCISE OF PRIVILEGES**

Every practitioner or allied health practitioner providing direct clinical services at the hospital by virtue of staff membership or otherwise shall, in connection with such practice and except as provided in Sections 4 and 5 be entitled to exercise only those clinical privileges or provide patient care services as are specifically granted pursuant to the provisions of these Bylaws and the Staff Rules and Regulations.

#### **2. DELINEATION OF PRIVILEGES IN GENERAL**

##### 2-1 Request

Each application for appointment and reappointment to the staff must contain a request for the clinical privileges desired by the applicant. A request by a staff member for modification of privileges must be supported by documentation of training and/or experience in support of this request.

##### 2-2 Bases for Privileges Determination

Requests for clinical privileges shall be evaluated on the basis of the practitioner's education, training, experience, and demonstrated competence and judgment. The bases for privilege determination to be made in connection with periodic reappointment or otherwise shall include observed clinical performance and the documented results of the quality/utilization management activities required by these bylaws to be conducted at the hospital. Privilege determination shall also be based on pertinent information concerning clinical performance obtained from other sources including, but not limited to, other health care facilities where a practitioner exercises clinical privileges. This information shall be added to and maintained in the staff file established for a staff member.

##### 2-3 Surgical Privileges/Invasive

A physician applicant for staff appointment seeking surgical/invasive privileges, other than for minor surgery as defined by the Medical Staff, must have completed a surgical residency or other specialty residency approved by the American Osteopathic Association or the Accreditation Council For Graduate Medical Education (ACGME) sufficient to satisfy the specialty board requirements for eligibility to become certified, in effect at the date application for staff appointment is submitted.

##### 2-4 Special Conditions for Podiatric Privileges

- A. A podiatrist applicant for appointment seeking podiatric surgery privileges must have completed a residency training program in podiatry as approved by the American Board of Podiatric Surgery sufficient to satisfy the specialty board requirements for eligibility to become certified, in effect the date the application for staff appointment is submitted.
- B. Requests for clinical privileges from podiatrists shall be processed in the same manner as specified in Section III.2. Surgical procedures performed by podiatrists shall be under the monitoring of the Chairman of the Department of Surgery. All podiatric patients shall

receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient.

## 2-5 Procedure

All requests for clinical privileges shall be processed pursuant to procedures for Appointment.

### **MEDICAL STAFF CREDENTIALING MANUAL**

#### **III. DETERMINATION OF CLINICAL PRIVILEGES.....**

#### **3. Voluntary Relinquishment of Clinical Privileges<sup>1</sup>**

<sup>1</sup> *Medical Staff Leader Handbook: On-Call Issues: Harty Springer Publications*

- 3-1. A Medical Staff member may request voluntary relinquishment of any one or more clinical privileges by submitting a written request to the department chairperson specifying the clinical privilege(s) to be relinquished.
- 3.2. The Department Chair shall report to the Staff Executive Committee as to whether the relinquishment of the privilege(s) would create an unreasonable burden on the on-call schedule.
- 3.3. The Staff Executive Committee may request meeting with the member involved if the decrease of the clinical privileges would create a burden on the on-call rotation. The Staff Executive committee shall make a recommendation to the Board of Trustees.
- 3.4. The Board of Trustees shall make the final decision on the request based upon, among other factors, how the request will affect the hospital's ability to comply with applicable requirements, including the Emergency Medical Treatment and Active Labor Act (EMTALA). The Board's decision shall be reported in writing by the Chief Executive Officer to the physician, the Staff Executive Committee, and the Chair of the applicable department. If the Board's decision is to grant the relinquishment of privileges, it shall specify the date on which relinquishment of clinical privileges shall become effective.
- 3.5. Failure of a member to request relinquishment of clinical privileges a set forth above shall result in the member being maintained on the call schedule without any change to his/her call responsibilities.
- 3.6. Members who have voluntarily limited their practice to include less than core privileges typically associated with their specialty may be required to participate in a general on-call schedule, and to maintain sufficient competence to fulfill the responsibility. If a member does not feel clinical competent to take general call, the member is responsible to arrange for appropriate coverage.

#### 4. ALLIED HEALTH PROFESSIONALS (see AHP Policy Manual)

The Medical Staff may recommend to the Board the granting of clinical privileges to Allied Health Professionals (AHP) according to procedures established in the Medical Staff Bylaws and related policies governing the AHP's practice in the hospital. A recommendation by or on behalf of the Medical Staff to not grant privileges to an applicant for privileges as an independent AHP (Medical Associate), or to suspend, or terminate, or to discontinue such privileges or such decision by the Board, shall give rise to procedural rights as set forth in Article VIII and the Fair Hearing Plan.

##### 4-1 Special Conditions for Dental Privileges

- A. A dentist applicant for appointment seeking oral surgery privileges must have completed a residency training program in oral surgery approved by the American Dental Association Commission on the Dental Accreditation sufficient to satisfy the specialty board requirements for eligibility to become certified, in effect at the date the application is submitted.
- B. Request for clinical privileges from dentists shall be processed in the same manner as specified in Section 2. Surgical procedures performed by dentists shall be under the monitoring of the Chairman of the Department of EENT & PS. All dental patients shall receive the same basic medical appraisal as patients admitted to the other surgical services. A physician member of the staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient. Except in the event of an emergency, the responsible physician member of the staff shall be identified prior to admission of the patient for surgery to be performed by a dentist member of the staff.

#### 5. TEMPORARY PRIVILEGES

##### 5-1 Circumstances

Upon written concurrence of the Chairman of the Department where the privileges will be exercised, the Chief Medical Officer or the Chief of Staff, may grant temporary privileges in the following circumstances:

- A. Pendency of Application: (INTERIM APPOINTMENT): After receipt of an application for staff appointment, including a request for specific temporary privileges, and in accordance with the conditions specified in Section III.2, (Basic Qualifications for Medical Staff Membership), an appropriately licensed applicant may be granted INTERIM appointment and/or privileges during the pendency of the application which should exceed no more than sixty (60) days. These temporary privileges will be considered only after verification of licensure, DEA, training, insurance, NPDB, and a minimum of one reference from previous facility. In exercising such privileges, the applicant shall act under the supervision of the chairman of the department to which he is assigned;
- B. Care of Specific Patients: Upon receipt of a written request, an appropriately licensed practitioner who is not an applicant for membership may be granted temporary privileges for the care of one or more specific patients.
- C. Locum Tenens: Upon receipt of a written request, an appropriately licensed practitioner who is serving as a locum tenens for a member of the staff may, without applying or membership on the staff, be granted temporary privileges for specific periods of time which are not sequential.

## 5-2 Conditions

Temporary privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting practitioner's qualifications, ability and judgment to exercise the privileges requested, and only after the practitioner has provided evidence of professional liability insurance coverage or other evidence of financial responsibility in accordance with Section 3.2-1C of the Medical Staff Bylaws. Special requirements of consultation and reporting may be imposed by the Chairman of the Department responsible for supervision of a practitioner granted temporary privileges. Before temporary privileges are granted, the practitioner must acknowledge in writing that he has received and read the Medical Staff Bylaws, and Staff Rules and Regulations, and that he agrees to be bound by the terms thereof in all matters relating to his temporary privileges.

## 5-3 Termination

On the discovery of any information, or the occurrence of any event of a professionally questionable nature, pertinent to a practitioner's qualifications or ability to exercise any or all of the temporary privileges granted, the department chairman responsible for supervision, or the Chief Medical Officer, after consultation with the department chairman responsible for supervision or the Chief of Staff, may terminate any or all of such practitioner's temporary privileges, provided that where the life or well-being of a patient is determined to be endangered by continued treatment by the practitioner, the termination may be effected by a person entitled to impose summary suspension under Article VII of the Medical Staff Bylaws. In the event of any such termination, the practitioner's patients then in the hospital shall be assigned to another practitioner by the department chairman responsible for supervision. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner. The terminated practitioner shall confer with the substitute practitioner to the extent necessary to safeguard the patient.

## 5-4 Rights of the Practitioner

A practitioner shall not be entitled to the procedural rights afforded by Articles VIII and of the Medical Staff Bylaws and the Fair Hearing Plan because of his inability to obtain temporary privileges or because of any termination or suspension of temporary privileges.

# 6. EMERGENCY PRIVILEGES

## 6-1. Definition of Emergency Privileges:

For the purposes of this section, an "emergency" is defined as a condition in which serious or permanent harm would result to a patient, or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger. In the case of an emergency, any practitioner, to the degree permitted by his license, regardless of department, staff status, or clinical privileges, shall be permitted to do, and shall be assisted by hospital personnel in doing, everything possible to save the life of a patient or to save a patient from serious harm. A practitioner utilizing emergency privileges shall promptly provide to the Staff Executive Committee in writing a statement explaining the circumstances giving rise to the emergency.



6-2. Emergency / DISASTER Privileges:

In circumstances of a disaster in which the hospital's external disaster plan has been activated, and there is not adequate staff to provide emergency care to all patients presenting to the hospital, and physicians and other professionals volunteer to provide care, the Chief Medical Officer, Chief of Staff, or their designee may approve emergency privileges to licensed independent practitioners (LIP) having acceptable sources of licensure and identification.

Emergency privileges will be granted upon review and evaluation of: a government issued photo ID\*, in addition to another identification source such as:

- a. A current picture hospital ID
- b. A current license to practice and a valid ID issued by a state, federal, or regulatory agency
- c. Identification indicating that the individual is a member of a Disaster Medical Assistant Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advanced Registration of Volunteer Health Professionals (SAR-VHP), or another recognized State or Federal response organization or group.
- d. Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state or municipal entity

The Medical Affairs Department will *initiate primary source verification of licensure within 72 hours from the time the volunteer licensed independent practitioner presents themselves to the hospital. If primary source verification cannot be completed within the requisite time frame due to extraordinary circumstances, documentation will be recorded in accordance with the Hospital's "Disaster Management Plan" specific to Volunteer Practitioners and Independent License Practitioners.*

Emergency privileges in disaster circumstances shall cease once the external disaster plan has been de-activated and patient care can be safely yielded to qualified members of MCRMC medical staff.

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APPENDIX A-1 Ongoing Monitoring of Sanctions / Complaints (Delegated Credentialing Responsibilities)	(2015)
APPENDIX A-2 References for Sources to Primary Verification for Provider Applications (Required & Non-Required)	(2007)
APPENDIX B. Credentialing Policy re: New / Unusual Procedures or New Technology	(2009)

Original Approval: General Staff July 13, 1989 Board of Trustees July 18, 1989

Reviewed/Amended: March, 1998; November, 2000; April, 2003; June, 2004; Dec06/January 2007; January 2012;  
March 2015, January 2016