

Briefings on

# Credentialing

The monthly newsletter  
for medical services  
professionals

## Developing credentialing and privileging policies for low- and no-volume practitioners

If you process low- and no-volume practitioners using the same policies designed for other members of the medical staff, you're setting yourself and the applicant up for problems. By definition, these practitioners have a different clinical experience than other members of the medical staff, so the way MSPs review their credentials and assign privileges—if they do this at all—needs to be tailored to that specific population.

### Is a new strategy really needed?

**Rick Sheff, MD**, chair and executive director of The Greeley Company, a division of HCPro, Inc., in Marblehead, MA, says using the standard medical staff policies raises issues such as:

- Matching privileges with demonstrated competency
- Assessing risk management and compliance

- Securing referrals and loyalty
- Cherry-picking of payer mix (i.e., sending wealthy patients to the physician's preferred hospital, and patients who have difficulty paying to the hospital where the physician has low- and no-volume status)

However, although there may be extra challenges in processing their applications, there is no intrinsic reason why hospitals should eliminate these practitioners from the medical staff. In fact, there are even benefits for hospitals that choose to maintain these ties, says Sheff. Low- and no-volume practitioners are able to refer patients to the hospital or to other members of the medical staff, participate in community outreach programs on behalf of the hospital, and provide a continuation of care for patients after they are discharged from the hospital, offering patients a sense of community.

#### Enclosed:

This month's **Clinical Privilege White Papers:**

- **Postresidency surgical education and training (update)**—Special Report 1007
- **Pulmonary disease (update)**—Practice area 143



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Pericardiocente—*what?* Does medical terminology have you tongue-tied? Put down your dictionary long enough to read our latest Credentialing 101 article.

- p. 6 Core privileging forms sneak preview**  
Here's your chance to read some of the latest changes included in HCPro's new *Core Privileges for Physicians* book before it hits the shelves. Remember, you saw it here first!
- p. 8 The DEA speaks about DEA registrations**  
Members of the Drug Enforcement Administration share their registration verification tips with MSPs.
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Find the latest news from the field in the areas of credentialing and privileging.

### A policy is an MSP's most important tool

Your organization can reduce the problems that do arise when MSPs credential and privilege these practitioners by developing and adhering to a policy for low- and no-volume practitioners, and by placing the burden of documentation on the applicant, regardless of how many patients the physician treats in your facility. This is especially important for MSPs to do when a physician's level of competency is called into question during the reappointment process, which is often the case for low- and no-volume practitioners.

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## Keeping the medical staff in compliance with federal laws

### MSPs fulfill their gatekeeper roles by verifying DEA registrations

Verifying a practitioner's Federal Drug Enforcement Administration (DEA) registration may not be a complicated task for an MSP, but it is essential for ensuring

**“. . . You must be licensed to practice medicine in the state that you're going to dispense a controlled substance [in].”**

—Gary Boggs

that controlled substances don't fall into the wrong hands.

The Joint Commission (formerly JCAHO) requires that orga-

nized medical staffs evaluate a practitioner's abilities to function as a DEA registrant (i.e., his or her ability to write prescriptions for controlled substances); however, no specific method for doing so is given. Typically, best practice for verifying a DEA registration is for the MSP to obtain one of the following:

- A copy of the practitioner's current DEA registration
- A confirmation from the issuing body
- Confirmation from a recognized verification

#### DEA museum exhibit has familiar focus

The latest exhibit to open at the Drug Enforcement Administration (DEA) Museum and Visitor's Center in Arlington, VA, covers a subject matter familiar to MSPs charged with verifying DEA registrations. "Good Medicine, Bad Behavior: Drug Diversion in America," tells the tale of how controlled substances meant for the greater good can sometimes fall into the wrong hands. **Sean Ferns**, museum spokesperson, says, "The goal of the exhibit is to educate the visitors, both the general public as well as the medical professionals whom DEA regulates, that, unlike street drugs, this issue comes right into the home, right into the hospital, right into the pharmacy."

Visit the museum's Web site for more information at [www.deamuseum.org](http://www.deamuseum.org)

organization (e.g., the National Practitioner Data Bank) that the practitioner is a valid DEA registrant

**Michael Callahan**, an attorney in the healthcare department of Katten Muchin Roseman, LLP, in Chicago, acknowledges that not a lot of time is spent verifying DEA registrations. (*Note:* Although the DEA only uses the term "registration" to refer to this authorized document, it is also called a certificate or license.) "If I'm a[n] MSP, I just want to see your license and make sure it checks out, because I've got a million other things to worry about," he says. However, if a practitioner forgets to renew his or her registration, then it becomes a bigger issue, says Callahan, because that individual is no longer allowed to write prescriptions, and it may affect his or her medical staff privileges.

Specific information about the consequences of an expired or suspended DEA certificate should be found in an organization's bylaws or policies. "If they're not there, then they should be there," says Callahan. "If a practitioner continues to write prescriptions with an expired license, this conduct could lead to increased malpractice exposure for both the physician and the hospital, as well as loss of the physician's license to practice medicine."

#### The optional DEA registration

It is important to note that not all practitioners need to have a DEA registration, and MSPs can save time by knowing their organization's stance on this. "If you manufacture, distribute, or dispense a controlled substance, or a [chemical used to manufacture a controlled substance]; if you import it, export it, anything like that, you must be a DEA registrant," says **Gary Boggs**, executive assistant to the deputy assistant administrator of the DEA's Office of Diversion Control. "If all the practitioner wants to do is dispense through prescriptions noncontrolled substances, like lifestyle drugs or antibiotics," he says, "you don't need to be a DEA registrant because those

are noncontrolled substances, even though [the patient] needs a prescription.”

“If you are a practitioner in addition to being a DEA registrant, you must be licensed to practice medicine in the state that you’re going to dispense a controlled substance [in],” says Boggs.

Callahan says that some healthcare organizations may require all practitioners to have a DEA registration, regardless of whether they ever use it to write prescriptions. He has worked with some hospitals to modify this requirement. “We’ve actually developed language in some of our bylaws that if you need to write prescriptions in order to exercise your clinical privileges, then you need a DEA license. If you don’t, then you don’t. It’s one less expense for the physician, and one less expense for the hospital in terms of doing its credentialing,” he says.

A practitioner needs to renew his or her DEA registration every three years. In most organization’s bylaws and policies, failure by a practitioner to renew a DEA registration leads to an automatic suspension of medical staff privileges, says Callahan. If a practitioner continues to write prescriptions with an expired registration, that could lead to greater legal issues.

### Blowing the whistle on bad behavior

Boggs emphasizes that it is an extremely small percentage of practitioners that incurs criminal prosecution because of a misused DEA registration. (For example, this could happen if a practitioner uses a stolen DEA registration to write prescriptions for controlled substances.) He says that about 98% of the total DEA registrant population are practitioners, and of that, “probably less than one-tenth of 1%” face criminal violations for misusing these registrations. “Most of them are good stewards of their DEA registration,” says Boggs.

However, if an MSP suspects that a practitioner is using a stolen DEA registration as his or her own, or if a practitioner is abusing the registration, then the MSP should contact the local DEA office, says Boggs. All of the contact information for local offices can be found on the DEA’s Office of Diversion Control Web site, as well

as information about practitioners who are known DEA offenders.

The DEA also works closely with the state medical boards to exchange information about practitioners who are under investigation. “If they revoke the state license, then we may take steps to revoke the DEA registration,” says Boggs, because a practitioner can’t have a DEA registration without a medical license. Although most MSPs will never have to blow the whistle on a practitioner for misusing, or even failing to renew, a DEA registration, Callahan says you should know what to do in case the situation arises. Hospitals, patients, and the entire medical staff count on MSPs to fulfill their role as gatekeepers by helping to regulate the flow of controlled substances. ■

### Reader survey: What changes are you planning for 2008?

A lot has changed for the medical staff office over the years. Some of those changes have been gradual, and others seem to have taken place overnight. As you look ahead to 2008, we’d like to know what changes you’re planning for the future.

- Is this the year to make the jump to a paperless credentialing system?
- Are you in the market for a new privileging software system?
- Will you be hiring a consultant? What types of problems are you seeking advice for?
- What new technologies are you developing privileging forms for?
- Has your office started preparing for revisions to The Joint Commission’s (formerly JCAHO) Standard MS.1.20 (effective September 1, 2009)?
- Do you have any continuing education plans? Which conferences will you attend?

Please e-mail your responses to Associate Editor Emily Berry at [eberry@hcpro.com](mailto:eberry@hcpro.com). Survey results will be shared in future issues of **Briefings on Credentialing**. Thank you and best wishes for 2008!