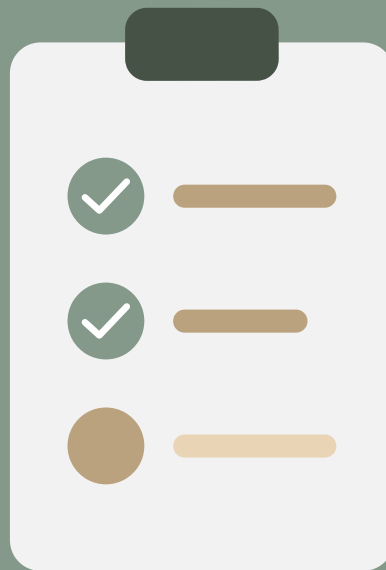


Hospital Credentialing, Explained Simply

How a doctor or other provider gets
approved to care for patients at a hospital



All Things Credentialing | Training Overview

What is credentialing?

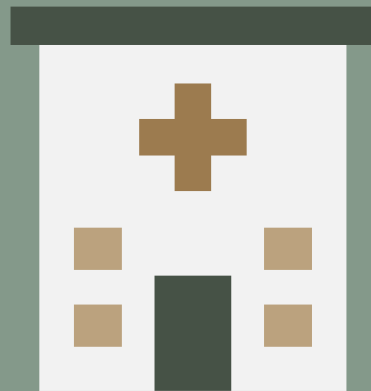
Credentialing is how a hospital checks that a doctor, nurse practitioner, or other provider is who they say they are and has the education, training, license, and experience to safely care for patients.



Think of it like a very thorough background and qualifications check, done before anyone treats a patient, and repeated regularly.



Why credentialing matters



Patient safety



Only qualified, safe providers get to treat patients.

Required by rules



Medicare's rules (from CMS) and The Joint Commission, a hospital accreditor, require it.

Legal protection



Hospitals can be held responsible for approving a provider carelessly.

Getting paid



Insurers and Medicare pay only for providers who are credentialed and enrolled with them.

Credentialing vs. privileging



CREDENTIALING

Are they qualified?

What it checks

The provider's license, education, training, board certification (a specialty exam), work history, and background.



PRIVILEGING

What are they allowed to do here?

What it decides

Which specific procedures and patient care the provider may perform at this hospital, based on proven training and experience.

Credentialing comes first. Privileges are granted on top of it.

Who's involved



Provider

Applies and supplies documents.



Medical Staff Office

The credentialing specialists. They collect and verify everything.



Department Chair

Reviews the provider's fit and the privileges requested.



Credentials Committee

Physician peers who review the file.



MEC

Medical Executive Committee. Staff leaders who recommend approval.

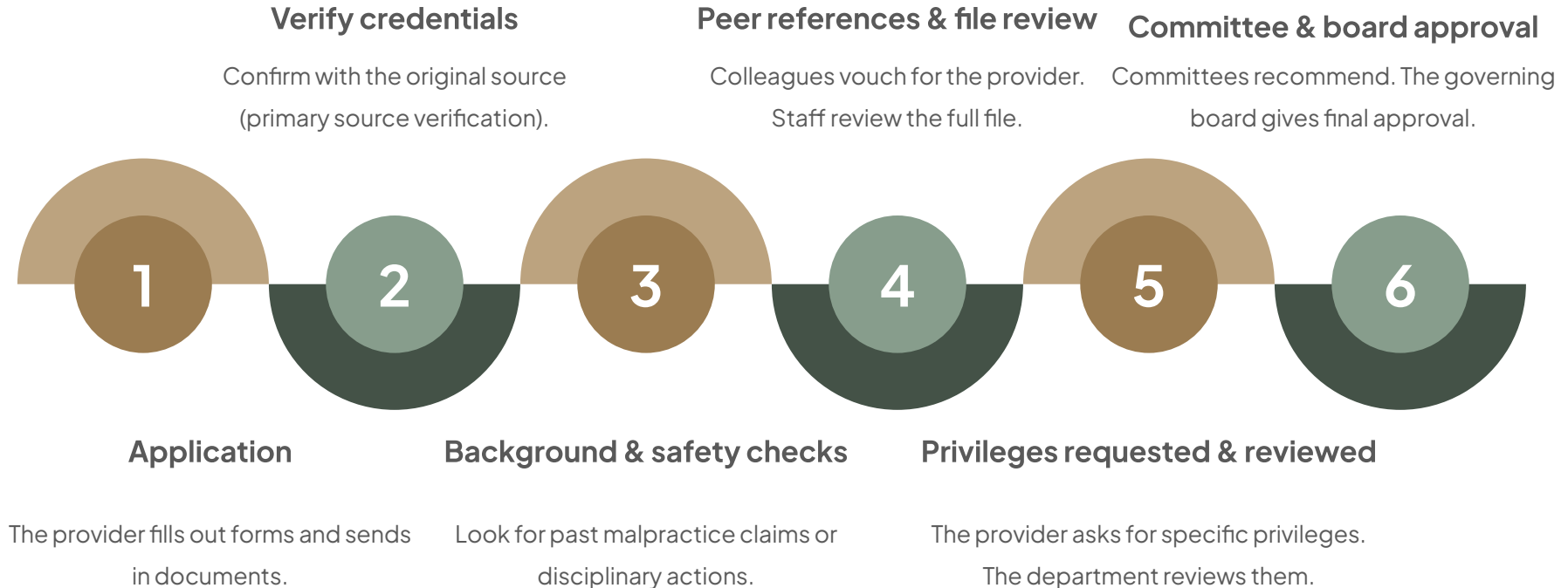


Governing Board

The hospital's board. It gives final approval.

The big picture: 6 steps

Most hospitals aim to finish in about 60 to 90 days, depending on their bylaws.



1

STEP 1 OF 6



What they submit

Application form
CV (work history)
Licenses
DEA registration
Board certificate
Malpractice insurance
Photo ID



What they sign

A release letting the hospital check their background, plus attestations: honest answers about health, discipline, and lawsuits.



The application

Where it all starts

The provider fills out an application and sends in their documents.

Good to know: the clock usually starts when the application is complete, meaning every form and document is in.

2

STEP 2 OF 6



Primary source verification

We confirm each credential directly with the organization that issued it, not just a copy from the provider.



State license

Checked with the state medical or nursing board.



Education & training

Medical school, residency, fellowship, or APP (advanced practice provider) program.



Board certification

Checked with the specialty board, for example via ABMS Certification Matters.



DEA registration

For prescribing controlled substances. Checked with the DEA.

Background & safety checks



NPDB check

The National Practitioner Data Bank: a federal database of malpractice payments and disciplinary actions. Hospitals must check it.



Exclusion lists

OIG and SAM.gov list people banned from Medicare, Medicaid, and other federal programs. The state Medicaid list is checked too.



Malpractice history

Claims history from the provider's insurance carriers, plus the provider's explanation of any claims.

Peer references & file review

Other practitioners who have worked with the provider confirm their skills and professionalism, usually 2 to 3 peer references. Then the credentialing specialist reviews the whole file.

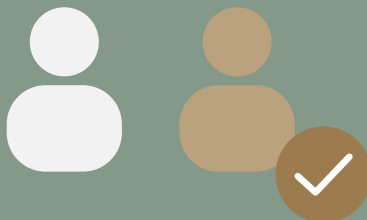


Clean file

Everything is verified and there are no concerns, so it moves forward.

4

STEP 4 OF 6



File with issues

Gaps in work history, malpractice claims, discipline, or “yes” answers on the application need more review and written explanations.

5

STEP 5 OF 6



Privileges

What a provider may do here

Privileges are the specific things a provider is approved to do at this hospital, like admitting patients or performing a certain surgery.

01

The provider requests privileges on a form called the Delineation of Privileges (DOP).

02

They show proof they're competent, such as training, case logs, and certifications (for example, ACLS for life support).

03

The department chair reviews the request and makes a recommendation.

Approval path

The file moves up a chain of review. Each group recommends, and the board makes the final decision.



01 Credentials Committee

Physician peers review the file and recommend.

02 MEC

The Medical Executive Committee: medical staff leaders recommend.

03 Governing Board

The hospital's board gives final approval.

Once the board approves, the provider is appointed to the medical staff with their approved privileges.



Timeline & the 180-day rule

180

days

Many hospitals set a target turnaround of 60 to 90 days.

Verifications must be fresh.

Most accreditation standards expect them to be no more than about 180 days old when the committee makes its decision.

If a file sits too long, some checks have to be redone, so moving files promptly matters.

Temporary privileges & FPPE

Temporary privileges

Short-term approval so a provider can start sooner.



When: there's an urgent patient-care need, or a complete, clean application is waiting on committee.



Who: granted by the CEO or designee, on the recommendation of medical staff leaders.



How long: under Joint Commission standards, limited to 120 days.

120

day limit

FPPE

**Focused Professional
Practice Evaluation**

A period of closer review, such as proctoring or chart review, for every new provider or new privilege, to confirm they perform as expected.



After approval

Approval isn't the finish line. The hospital keeps checking, and the whole process repeats.



OPPE

Ongoing

Ongoing Professional Practice Evaluation: performance data is reviewed regularly, often every 6 to 12 months.

Monitoring

Continuous

License expirations are tracked, exclusion lists are checked monthly, and NPDB Continuous Query sends alerts.

Recredentialing

2–3 years

Reappointment happens at least every 3 years under Joint Commission standards (CMS recommends 24 months if state law sets no timeframe); follow your bylaws.

ABC

CHEAT SHEET

Key terms cheat sheet

Keep this handy. Each term in one plain line.

**Credentialing**

Checking a provider's qualifications.

**MEC**

The Medical Executive Committee: medical staff leaders.

**Privileges**

What a provider may do at this hospital.

**DOP**

Delineation of Privileges: the privilege request form.

**PSV**

Primary source verification: confirming directly with the issuing source.

**FPPE**

Focused review for new providers or new privileges.

**NPDB**

The federal database of malpractice payments and discipline.

**OPPE**

Ongoing performance review.

Recap

- Credentialing confirms a provider is qualified. Privileging decides what they can do here.
- Every credential is checked at the original source.
- Peers, committees, and the board all review before approval.
- It doesn't stop: monitoring is ongoing and reappointment happens at least every 3 years under Joint Commission standards (CMS recommends 24 months if state law sets no timeframe); follow your bylaws.



Questions?

No question is too basic.

