Ambulatory Surgical Center	Federal term, defined in CFR Title 42§416.2 Ambulatory surgical center or ASC means any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization, has an agreement with CMS to participate in Medicare as an ASC, and meets the conditions set forth in subparts B and C of this part. Subparts B and C relate to accreditation, refund and information terms, agreement to meet conditions for coverage, including having a governing body, agreements for immediate transfer to a hospital for emergency care beyond the capabilities of the ASC, specified use of anesthesiology, discharge prior to midnight on day of admission, and architectural/equipment standards.
Credentialing	Two terms: Economic Credentialing and Physician Credentialing **Economic Credentialing**: The usual definition cited[1] is that of the American College of Medical Quality (and includes an opinion at the end): Economic credentialing defines a health care professional's qualifications based solely on economic factors which are unrelated to the individual's ability to make medical review or direct clinical care decisions consistent with the applicable standard of care. It involves the use of economic criteria by a health care organization as the only factor which determines a physician's or other health care professional's qualifications for initiation, continuation, or revocation of medical care or peer review privileges. As such, economic credentialing impedes the professional's role as the patient's advocate, represents an inappropriate basis for credentialing, and should be considered professionally unacceptable. The American Medical Association definition (3/14/2005) is: Economic credentialing is the use of economic criteria unrelated to quality of care or professional competence in determining a physician's qualifications for initial or continuing hospital medical staff membership or privileges. (used in original SB 312) SB 312, as enacted, provided the following definition: (a) "Economic credentialing" means the denial of a physician's application for staff membership or clinical privileges to practice medicine in a hospital on criteria other than the individual's training, current competence, experience, ability, personal character, and judgment. This term does not mean use by the hospital of: (i) exclusive contracts with physicians; (ii) medical staff on-call requirements; (iii) adherence to a formulary approved by the medical staff; or (iv) other medical staff policy adopted to manage health care costs or improve quality.

Definition published in *Physician's News Digest* (April 2006)

> Economic credentialing is any practice by which a hospital conditions the granting of staff privileges on the physician providing a certain volume of services at, or referring a certain number of patients to, the hospital or the physician not investing in competing facilities.[2]

Article in *Physician Executive* (Nov-Dec. 1991)

> "In one meaning, economic credentialing is the process in which hospital privileges are granted or renewed based on the economic impact of a provider's prior utilization experience, taking into account patient health needs and ultimate outcomes. ... The other definition... Pure economic credentialing does not take into account the quality of care rendered or the particular physician's patient mix. The sole issue is whether or not the procedure was economically appropriate, rather than whether it was medically justified and economically appropriate.

Physician Credentialing

From an American College of Medical Quality Policy Statement:

> "Credentialing or re-credentialing is the process of formal recognition and attestation of current medical professional or technical competence and performance by evaluating and monitoring a physician's clinical or medical review decision-making by adherence to the professional standard for direct medical care or peer review. In addition, credentialing verifies an individual's license, experience, certification, education, training, malpractice and adverse clinical occurrences, clinical judgment, technical capabilities, and character by investigation and observation. It defines a physician's scope of practice and the clinical or review services he or she may provide, and ensures that physicians provide services within the scope of privileges granted. Credentialing must be the product of qualified and objective physician-controlled peer review, utilizing criteria that have been established through common legal, professional and administrative practices, endorsed by a formal consensus process, and that are publicly available. These criteria must be directly related to quality of patient care, and documented physician performance should be measured against these criteria. *http://www.acmq.org/policies/policy21.pdf*

SJR 15 defines Physician credentialing as:

> "... the process that hospitals use for granting privileges to physicians to practice in their facilities, including the use of hospitals by physicians who may be in competition with that hospital".

In addition to hospitals using physician credentialing to determine whether to grant privileges to physicians, each insurer may require physician credentialing. For example, Blue Cross Blue Shield of Montana lists its individual provider credentialing standards on its website. Minimum eligibility criteria are: licensure (license to practice in Montana), education, malpractice coverage, eligibility for Medicare/Medicaid programs. Each provider has different education criteria. To participate in a BCBSMT

	network, a physician must be board-certified in his/her area of practice or have completed residency training as specified. The BCBSMT definition is: "Credentialing is the process for validating the qualifications of licensed professionals and assessing their backgrounds. The process is an objective evaluation fo aperson's licensure, training, experience, competence and ability to provide particular services. It occurs at the commencement of employment or participation and at regular intervals thereafter (recredentialing)." (*from Theresa Stahly, BCBSMT credentialing coordinator in email 9/13/07)* Issues: Given that more than one approach to credentialing is possible, policy should be specific as to how to address one or other, if at all. Various states are addressing physician credentialing to streamline the task in an effort to keep paperwork and related costs at a minimum. Economic credentialing is at the crux of the debate between physician-owned practices and hospitals that grant privileges but probably would be moot if Congress bans physician self-referral.
Critical Access Hospital	From 50-5-101, MCA: (18) "Critical access hospital" means a facility that is located in a rural area, as defined in 42 U.S.C. 1395ww(d)(2)(D), and that has been designated by the department as a critical access hospital pursuant to 50-5-233. **50-5-233. Designation of critical access hospitals -- adoption of rules.** (1) The department may designate as a critical access hospital a facility that: (a) is: (i) located more than 35 road miles or, in the case of a facility located in mountainous terrain or where only secondary roads exist, more than 15 road miles from a hospital or another critical access hospital; or (ii) a necessary provider of health care services to residents of the area where the facility is located; (b) provides 24-hour emergency care that is necessary for ensuring access to emergency care services in the area served by the facility; (c) complies with the bed limitations adopted by rule, not to exceed the number specified in 42 U.S.C. 1395i-4(c)(2)(B), (c)(2)(E), and (f); (d) provides inpatient acute care for a period not exceeding 96 hours, as determined on an average, annual basis for each patient; (e) complies with the staffing requirements of 42 U.S.C. 1395i-4(c)(2)(B)(iv); and (f) operates a quality assessment and performance improvement program and follows appropriate procedures for review of utilization of services as specified in 42 U.S.C. 1395x(aa)(2)(I). (Subsection 2 is not listed here, referring to rulemaking)

DRGs	**Diagnostic Related Groups** - Assigned to medical services and used for determining Medicare/other reimbursements. Services with lucrative reimbursements (generally not general medicine) are those that reportedly are chosen for specialty hospital services.
EMTALA	Stands for Emergency Medical Treatment and Advanced Labor Act. Usually cited in connection with the costs of emergency rooms or departments to hospitals because of the obligation to treat. See "Obligation to Treat"
Health Care Facility	From 50-5-101, MCA (23) (a) "Health care facility" or "facility" means all or a portion of an institution, building, or agency, private or public, excluding federal facilities, whether organized for profit or not, that is used, operated, or designed to provide health services, medical treatment, or nursing, rehabilitative, or preventive care to any individual. The term includes chemical dependency facilities, critical access hospitals, end-stage renal dialysis facilities, home health agencies, home infusion therapy agencies, hospices, hospitals, infirmaries, long-term care facilities, intermediate care facilities for the developmentally disabled, medical assistance facilities, mental health centers, outpatient centers for primary care, outpatient centers for surgical services, rehabilitation facilities, residential care facilities, and residential treatment facilities. (b) The term does not include offices of private physicians, dentists, or other physical or mental health care workers regulated under Title 37, including licensed addiction counselors. This definition is important because the reference to licensure of health care facilities in Title 50, chapter 5, does not require licensure of offices operated by radiologists, including imaging centers, because radiologists are licensed as physicians under Title 37. Some facilities may request licensing to help them obtain third-party reimbursement for services. If a facility type is not listed as a health care facility, with a definition of service, then no license is required because there is no statutory prohibition of the service.
Hospital	From 50-5-101, MCA (28) (a) "Hospital" means a facility providing, by or under the supervision of licensed physicians, services for medical diagnosis, treatment, rehabilitation, and care of injured, disabled, or sick individuals. Except as otherwise provided by law, services provided may or may not include obstetrical care, emergency care, or any other service allowed by state licensing authority. A hospital has an organized medical staff that is on call and available within 20 minutes, 24 hours a day, 7 days a week, and provides 24-hour nursing care by licensed registered nurses. The term includes: (i) hospitals specializing in providing health services for psychiatric, developmentally disabled, and tubercular patients; and (ii) specialty hospitals. (b) The term does not include critical access hospitals.

Hospitalist	From the Society of Hospital Medicine: "Hospitalists are physicians whose primary professional focus is the general medical care of hospitalized patients. They may engage in clinical care, teaching, research or leadership in the field of general hospital medicine. Their typical patients are frail, elderly and medically complex, with chronic diseases such as emphysema, congestive heart failure, diabetes and kidney disease. Pediatric hospitalists provide similar care to hospitalized children. ... The underlying concept was that a small number of inpatient-based physicians would improve the quality and coordination of care while controlling healthcare costs." http://www.hospitalmedicine.org/AM/Template.cfm?Section=Advocacy_Policy&Template=/CM/ContentDisplay.cfm&ContentID=13117 Issue: Hospitals employ physicians for efficiency, control. Patient's outpatient doctor does not necessarily follow patient's care in hospital. Debate is over whether hospitalist has full-care view vs. lack of history with patient and whether efficiency offsets that issue.
Imaging Centers	From 33-36-103, MCA (Managed Care Plan Network Adequacy and Quality Assurance) (8) "Facility" means an institution providing health care services or a health care setting, including but not limited to a hospital, medical assistance facility, or critical access hospital, as defined in 50-5-101, or other licensed inpatient center, an ambulatory surgical or treatment center, a skilled nursing center, a residential treatment center, a diagnostic, laboratory, an imaging center, or a rehabilitation or other therapeutic health setting. Issues: Physician owners at risk of economic credentialing if hospitals are concerned with competition. Costs of technology relate to health care costs. Need in communities is unclear because use may be related to unmet needs or to over-referral.
Obligation to Treat	Centers for Medicare and Medicaid Services (CMS): In 1986, Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.[3] Issue: Many people say this is a chief cause of uncompensated care.

Referral	Two options: Physician Referral and Self-Referral **Physician Referral or Physician Self-Referral:** Defined in SJR 15 as "physician self-referral -- referral for medical treatment by a physician to a facility in which the referring physician has an ownership interest". Issues: 1) Ability to determine which facility gets what type of business (in terms of acuity or assurance of being paid). 2) Hospitals may negotiate privileges/compensation based on referrals. 3) Insurance plans may influence physician referrals. 4) The Sept. 5 Federal Register printed CMS's final interpretation of the Stark Act on physician self-referral. The regulations go into effect 12/4/07.
	Self-referral Some laws allow a patient to self-refer, without a physician's referral. Issues: "over-use", overview of history, safety of results, efficiency, choice.
Specialty Hospitals	Federal Definition (1) in the 2003 Medicare Modernization Act: Specialty hospitals are "primarily or exclusively engaged in the care and treatment of one of the following categories: (i) Patients with a cardiac condition. (i) Patients with an orthopedic condition. (iii) Patients receiving a surgical procedure." Federal Definition (2) from the Medicare Payment Advisory Commission (MedPAC): Specialty hospitals are physician-owned; provide at least 45% of their Medicare cases in cardiac, orthopedic, or surgical services or at least 66% in two major diagnostic categories (MDCs), with the primary one being cardiac or orthopedic; had a minimum volume of at least 25 total Medicare cases during 2002; and have submitted Medicare cost reports and claims for 2002 (defined in the MedPAC 2005 report). Kansas Health Institute (KHI) Specialty Hospital Study: "Specialty hospitals meet the following criteria: • at least 45% of cases must be in cardiac, orthopedic, or surgical services, or • at least 66% of cases must be in two MDCs, with the primary one being cardiac or orthopedic. (An MDC is a broad diagnostic classification, usually grouped by body systems, e.g. circulatory system. The Kansas Health Institute says 25 MDCs, encompassing more than 500 DRGs, constitute the range of cases treated in hospitals. (p. 6 Specialty Hospitals, KHI) From 50-5-101, MCA (as amended in the 2007 legislative session) (55) (a) "Specialty hospital" means a subclass of hospital that is exclusively

	engaged in the diagnosis, care, or treatment of one or more of the following categories: (i) patients with a cardiac condition; (ii) patients with an orthopedic condition; (iii) patients undergoing a surgical procedure; or (iv) patients treated for cancer-related diseases and receiving oncology services. (b) For purposes of this subsection (55), a specialty hospital may provide other services for medical diagnosis, treatment, rehabilitation, and care of injured, disabled, or sick individuals as otherwise provided by law if the care encompasses 35% or less of the hospital services. (c) The term "specialty hospital" does not include: (i) psychiatric hospitals; (ii) rehabilitation hospitals; (iii) children's hospitals; (iv) long-term care hospitals; or (v) critical access hospitals.
	In terms of SJR 15 is the reference to specialty hospitals intended to include: • Ambulatory Surgical Centers (cardiac, orthopedic) • Birthing Centers • Joint Venture (Hospital-Physician Co-Owned Surgical/Outpatient Centers) • Imaging Centers • Other laboratories or specialty services done in offices of licensed providers? Under 42 U.S.C. 1395nn physicians are restricted from self-referral of certain designated health services to facilities in which they or immediate family member(s) have ownership or an investment interest or a compensation arrangement. General exceptions include most in-office ancillary services, services by same-group physician, and services billed by a group practice or entity "that is wholly owned" by the physician or group practice.

ENDNOTES

1. Paul F. Danello of Ropes & Gray LLP, "Economic Credentialing: Where is it Going?" and Policy 23 as amended by the American College of Medical Quality Board of Trustees, 2/21/04. Cited at: www.acmq.org/policies/policy23.pdf

2. John W. Jones, "Legal implications of economic credentialing", copyright Physician's News Digest, April 2006.

3. CMS Interpretive Guideline (http://www.cms.hhs.gov/manuals/Downloads/som107ap_v_emerg.pdf):
"If at least one-third of the sample cases reviewed were for the treatment of EMCs on an urgent basis without requiring a previously scheduled appointment, the area being evaluated is a dedicated emergency department, and therefore, the hospital has an EMTALA obligation. Hospitals that may meet this one-third criterion may be specialty hospitals (such as psychiatric hospitals), hospitals without “traditional” emergency departments, and urgent care centers. In addition, it is not relevant if the entity that meets the definition of a dedicated ED is not located on the campus of the main hospital."