Medical Staff Credentialing and Privileging Standard Operating Procedure Manual

Indian Health Service

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This SOP Manual supersedes the IHS Medical Staff Credentialing and Privileging Guide, Sept. 2005.

Developed under the direction of the Office of Quality, Indian Health Service Headquarters

Record of Changes

Version	Date	Name	Description	Section
1.0	September 2005	Martin Smith, Michele Gemelas	Initial Draft	All
2.0	September 2024	IHS SOP Manual Workgroup	Publication	All
3.0	October 2024	Dione Harjo, Christel Svingen	Comments received from field incorporated	• Page 5 – Added yearly attestation requirement. • Section 1, Page 6-7 - Added Distant Site, Medical Executive Committee, and Governing Body definitions. • Multiple pages – Changed all IHS Practitioner Acknowledgement & Release entries to IHS Conditions of Application and Release. • Section 6, page 47-48 – Removed validity of form for 1 year. • Section 6, Immunizations, pages 55-56 – Adjusted section to include immunizations are not required for staff that do not work onsite. • Section 7, page 67 – ACCC flowchart removed. • Section 11, page 90 – Adjusted credentialing by proxy definition. • Section 15, page 124 – New FAQ on affiliation verifications, Contracts/Hiring and under Verifications.

A special thanks to the following Standard Operating Procedure (SOP) Manual Workgroup members and reviewers for their valuable contributions to the SOP Manual:

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How to use this SOP Manual

SOP Update Process

To provide suggestions and/or edits of the IHM 3-1, this SOP Manual, or the next reiterations of the OMB-approved applications, tools, and forms, please contact the IHS Headquarters (HQ) Office of Quality (OQ) Credentialing Program.

The Indian Health Service (IHS) Indian Health Manual (IHM) Part 3 Professional Services, Chapter 1 Clinical Credentials and Privileges Program policy references this standard operating procedure (SOP) manual for the credentialing and privileging of all licensed practitioners (LPs) who are authorized by law and the facility to practice independently and who are granted privileges to provide patient care services at federally operated facilities. The purpose of this SOP is to define IHS requirements for credentialing and privileging verifications, software, and internal control processes to be implemented consistently across the IHS health care system. This SOP compliments the IHS IHM 3-1 policy to ensure that the IHS credentialing process is an objective, systematic, standardized, and consistent process with the goal to support patient safety by confirming the current competence, character, judgment, education, training, and licensure of clinical candidates. IHS facilities are expected to implement all standard work processes and procedures described in this manual and are required to complete a yearly attestation confirming that all credentialing and privileging policies and standard operating procedures are met.

This SOP Manual is structured as follows:

Section 1: Glossary

Additional Definitions

can be found in the IHM 3-1 policy.

Accreditation – Refers to the result of an evaluative process in which a health care organization undergoes an examination of its policies, procedures, and performance by an external organization or accrediting body to ensure that it is meeting predetermined standards or criteria, including standards set forth by The Centers for Medicare & Medicaid Services (CMS).

Adverse Action – The Health Care Quality Improvement Act (HCQIA) defines "adverse actions" as "reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in a health care entity." A practitioner in good standing should have no employer or work affiliation adverse professional review actions, as defined in the medical staff bylaws.

Distant site (DS) – The entity where the telemedicine practitioner is credentialed and privileged to provide telemedicine services.

Distant Site Telemedicine Entity (DSTE) – The site where the physician or licensed practitioner providing the telehealth service is located.

Executive Committee of the Medical Staff (MEC) – Responsible for reviewing each application for appointments and privileging. The MEC evaluates current competency, determines appropriateness of requested privileges, and makes a recommendation through the clinical director (CD), or designee, and the chief executive officer (CEO), or designee, to the GB. The MEC recommendation will incorporate the recommendations of the CD, Chief of Service or Department Chief (where applicable), and Credentialing Committee (where applicable).

Focused Professional Practice Evaluation (FPPE) – A time-limited clinical evaluation implemented when:

- a practitioner lacks documented evidence of having recently and competently performed the requested privilege(s) at the organization, requiring the medical staff to evaluate their privilege-specific competence.
- a question arises regarding a currently privileged practitioner's ability to provide safe, high-quality patient care (e.g., their data shows outliers from predetermined thresholds of acceptable performance). This is often referred to as "for-cause" FPPE.

Governing Body (GB) – The governance authority that manages and provides oversight of the IHS facility. The Governing Body has the

authority to grant, modify, or deny medical staff membership and clinical privileges to LPs.

Medical Staff Credentialing – A standard and ongoing process dedicated to collecting, assessing, verifying, and documenting credentials and qualifications for both new and reappointed LPs.

Ongoing professional practice evaluations (OPPE) – Regularly scheduled assessments that validate providers' competency to their *current* ability to maintain privileges or continue to safely practice within a given scope, according to their health care accreditation and regulatory body's standards.

Originating site (OS) – The site where patients are physically located when receiving telemedicine services.

Pronto(s) – A type of online templates in MD-Staff that electronically collect verifications from affiliation, peers, education, and organizations.

Primary source verification (PSV) – The process of verifying a credential from the original source.

Standard Work – A process that involves identifying, teaching, following, and enforcing the best practices for performing a task or job. The goal is to create a safe, efficient, repeatable work method to accomplish a task while simultaneously reducing waste and variability within the process.

Telehealth – A secure audio and video telecommunications system permits communication between a remotely located licensed practitioner (distant site) and the patient (originating site) to provide patient care and services.

Telemedicine Services – Clinical services provided from a distant site by practitioners to patients or between practitioners consulting on a patient's condition, located at an originating site via telehealth technologies.

Unrestricted License – No restrictions, special considerations, periods of monitoring, or probationary requirements associated with license, certification, or registration in any jurisdiction that restricts or in any way inhibits the ability of the practitioner to practice his or her profession in the specialty or clinical area for which the practitioner is licensed, certified, or registered, and being hired. This includes any

stipulations that may have a potential adverse impact on patients, the medical staff, or the efficiency of the facility.

Section 2: Credentialing and Privileging in Patient Safety

While meeting regulatory and accreditation requirements is often cited as a reason, the main goal of medical staff credentialing is to support patient safety. The IHS mission is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. This mission is partially accomplished by ensuring that all LPs approved to provide patient care services meet certain qualifications.

Negligent credentialing occurs when individuals involved in the credentialing and privileging of LPs know or should have known that an LP is not qualified by failing to screen the LP, or approves appointment or privileges of an LP who had clear indicators of quality of care issues. If the standard of care was not met and a LP injures a patient, the agency can be found separately liable for the negligent credentialing of this LP.

The following are considered landmark cases for negligent credentialing in the credentialing industry.

Darling v. Charleston Community Memorial Hospital

Prior to this case ruling in 1965, hospitals were considered charitable organizations and were immune from being sued under the Charitable Immunity Doctrine. The Supreme Court of Illinois overturned this doctrine and introduced the idea of corporate negligence, as defined by an organization failing to meet basic standards such as monitoring, supervising, and controlling quality care. The ruling determined that hospitals should follow guidelines from TJC, government standards, and their own organization standards to validate their LPs competency to provide high-quality and safe care.

The decision affected other court cases, such as Johnson v. Misericordia Community Hospital in 1991. It illustrated the need for hospitals to be prudent in selecting LPs that provide care to patients.

Summary of the Darling v. Charleston Community Memorial Hospital Case

Darling was a football player who broke his leg during a game. He had his leg placed in a cast by the on-call doctor, subsequently developed gangrene, and had to have his leg amputated below the knee. The plaintiff claimed—and the court agreed—that the hospital was negligent for two reasons: it failed to properly review the work of an independent doctor, and its nurses failed to administer necessary tests. Darling held that the hospital bylaws, licensing regulations, and

standards for hospital accreditation were sufficient evidence to establish the standard of care. Therefore, a lay jury was able to conclude from the evidence that the hospital had breached its duty to act as a reasonably careful hospital.

Other credentialing landmark cases:

Johnson v. Misericordia Community Hospital - The hospital was found liable for a patient injured by a physician who had failed to disclose pending malpractice cases and who lied about his privileges at other hospitals.

Frigo v. Silver Cross Hospital - The hospital was found liable for a podiatrist performing a bunionectomy on an ulcerated foot, resulting in osteomyelitis and subsequent amputation of the foot. The provider did not meet the privileging criteria to perform these procedures.

Larson v. Wasemiller—The hospital was found negligent in approving the provider's privileges on reappointment due to the provider's poor performance (10 prior malpractice claims, state board licensing actions, failed three times to pass board certification recertification exam). Negligence was based on what was known or what should have been known at the time of the credentialing decision.

Section 3: Types of Errors in Credentialing

Two primary types of errors can occur in the credentialing and privileging process: (1) Informational Errors and (2) Decisional Errors.

(1) **Informational Error** – Includes omissions or failures in gathering or disclosing critical information in the credentialing and privileging process. This type of error is committed by either not detecting something that is discoverable or not disclosing discoverable information to the MEC and GB, which affects a credentialing decision. For example, the affiliation or work history of a LP may be less than favorable and because of this, the MEC and GB may decide not to grant privileges to the provider. But if a Medical Service Professional (MSP) fails to primary source verify this discoverable information, the MEC and GB may inadvertently grant privileges to a provider with an unfavorable background.

Example 1: Incomplete Verification of Educational Credentials

Scenario: An applicant submits their application which includes a degree from a foreign medical school. The MSP attempts to verify the medical education, but when the MSP contacts the school they receive limited information due to communication barriers and does not follow up for a more complete verification.

Informational Error: The MSP accepts partial verification without further action to conclusively verify the medical school's degree or authenticity. The credentials are entered into the system as verified based on insufficient information.

Consequence: The oversight allows an LP who may not have completed an accredited or legitimate medical education program or who perhaps forged documentation to be granted privileges. This would compromise patient safety and the facility's compliance with standards.

Example 2: Failure to Document Sanctions and Disciplinary Actions

During the credentialing process, an applicant discloses that they were involved in a minor disciplinary action at a previous affiliation, which they claim was resolved without any impact on their privileges, but there are no supporting documents other than the LPs comments.

Informational Error: The MSP does not verify the affiliation where the minor disciplinary action occurred. In addition, the MSP does not identify the information to the MEC or the GB to consider in their recommendations and approvals. This lack of detailed documentation leads to an incomplete understanding of the applicant's professional history.

Consequence: By not fully verifying and documenting the applicant's past disciplinary action, the facility risks granting privileges to an LP with unresolved professional issues. This could again lead to legal or accreditation issues and potentially endanger patient care quality.

(2) **Decisional Error**—Pertains to inappropriate or misguided decisions made despite concerning information. This type of error is committed by the clinical staff and leadership in reviewing, recommending, and approving the file. It refers to less-than-favorable or negative information discovered and presented, but the choice is made to dismiss or ignore the concerning information.

Example 3: Ignoring Disciplinary Actions

Scenario: An applicant requesting medical staff privileges has a history of disciplinary actions at previous health care facilities, including a suspension of privileges due to professional misconduct. This information is available and verified during the credentialing process, as reported by the National Practitioner Data Bank (NPDB) and affiliation verifications with previous employers.

Decisional Error: Despite the clear and concerning evidence of past disciplinary issues that could directly impact patient safety and quality of care, the MEC and GB decide to dismiss these red flags due to the applicant's significant years of clinical experience and the shortage of LPs in the facility. The application is approved without additional investigation.

Consequence: The failure to address these disciplinary actions could lead to similar conduct at an IHS facility, potentially endangering patient safety and exposing the facility to legal and accreditation risks.

Example 4: Overlooking Gaps in Practice History

Scenario: During the credentialing process, it is noted that an applicant has significant unexplained gaps in their practice history. The information is noted in the application and partly verified through primary source verification, showing periods where the applicant was not practicing in any health care setting.

Decisional Error: The MSP, MEC, and GB observe these gaps but decide not investigate the reasons for these interruptions in practice. They rationalize that the applicant's recent performance in another state (where they practiced for six months) is sufficient to grant privileges without additional scrutiny or requirements for recent competency assessments.

Consequence: Ignoring gaps in practice history without understanding the reasons (such as approved leave, health issues, loss of license, or lack of competence) can lead to granting privileges to a practitioner who may not be capable of providing safe and competent care. This oversight can compromise patient care quality and increase the risk of adverse outcomes.

Both informational and decisional errors can increase the risk of potential harm to patients, create undesired media attention that tarnishes an entity's reputation, create TORT claims, instigate accreditation and investigation issues, and cause the loss of quality staff members. While all of these reasons are important, credentialing and privileging processes primarily aim to protect patients from harm. This is why the National Association of Medical Staff Services (NAMSS) refers to MSPs as the Gatekeepers of Patient Safety. When executed correctly, the credentialing process also protects the Agency and its providers.

Section 4: The Role of the MSP

The role of a Medical Services Professional (MSP) is pivotal in verifying that LPs meet the necessary standards of competence, thereby contributing to the provision of safe and high-quality care to patients. In the medical staff services industry, this position is described as the "Gatekeepers of Patient Safety." The shift towards the term 'MSP' more accurately reflects the crucial responsibilities involved in verifying, analyzing, and preparing credentialing and privileging files. This change underscores the significance of an MSP's role in upholding standards set by accreditation bodies, CMS Conditions of Participation (CoPs), agency policies, and local medical staff bylaws. Within the Indian Health Service, the scope of MSP responsibilities has expanded to encompass support for peer review, performance improvement, and third-party payer enrollment. This evolution illustrates the growing recognition of the MSP's role in enhancing health care quality and safety.

MSPs are one of the first contacts in health care delivery in verifying, analyzing, and preparing all relevant information in relation to an LPs competency, character, training, experience, and judgment and presenting a complete and accurate file to the MEC and GB for recommendations and approvals.

The MSP collects and maintains all LP files in MD-Staff, the official IHS system of record for credentialing and privileging, beginning with the application to final approval and ongoing through the appointment cycles.

It's important to remember that even the most robust credentialing software systems still require human intervention. Even though providers can complete their applications and associated documents electronically, and the credentialing software can verify information automatically, the MSPs, Medical Staff, and Governing Body still have the obligation to vet the LPs applications, credentials, and verifications.

Section 5: IHS Applications, Forms, and Tools

General Information

All LP applicants for medical staff appointment and/or clinical privileges must complete and submit the appropriate IHS-designated Office of Management and Budget (OMB) approved Application for Medical Staff Appointment and/or Privileges and its supplemental forms. The application and forms are submitted electronically through the IHS's credentialing software, henceforth referred to as "software" or "MD-Staff" in this SOP Manual. At publication of this SOP Manual, there are two OMB-approved applications, three OMB-approved tools, four OMB-approved forms, an Office of General Counsel (OGC) approved updated release, and four audit tools.

These OMB-approved applications, tools, and forms are available in the software and are designated by an OMB number and expiration date. New modified or updated versions of these applications, tools, and forms require OMB approval. The four audit tools are provided in the Appendix.

The use of these applications, tools, and forms are required to be used for IHS LP applicants. If the software is non-functioning or there is a disruption, OMB-approved paper applications and forms may be utilized during this time. For more information on the software procedures, see IHM 3-1.3L.

Credentialing Applications and Tools

The following are the types of electronic applications, tools, and forms available for use in the IHS Credentialing and Privileging process. The use of these applications and tools is further described in this section below.

Applications:

1) Initial Application
2) Reappointment Application

Tools:

1) Pre-Application
2) Credentialing by Proxy Intake Form

Forms:

1) Peer Reference

2) Affiliation
3) Education
4) Insurance

There are four audit tools that are used by the IHS Office of Quality Credentialing Division to conduct random audits of credentialing files. Audits are based on the minimum required elements in the IHM 3-1 policy and the SOP Manual. These Audit Forms are excellent tools to ensure all tasks are completed within a credentialing and privileging process:

1) IHS Initial Appointment Audit Form
2) IHS Reappointment Audit Form
3) IHS Additional Privileges Audit Form
4) IHS Disaster Privileges Audit Form

Finally, the former release, known as the SOUR (Statement of Understanding and Release), has been updated to the IHS Conditions of Application and Release. More information is on pages 24-25 in the Forms Section; see Provider Release Form.

General Information: Initial and Reappointment Applications

The MSP must ensure the information provided by the LP on the applications and tools is complete, accurate, and current by reviewing, analyzing, and verifying the provided information with primary sources (where available) and providing support for credentialing-related tasks within the medical staff office.

The medical staff initial and reappointment applications are similar to a human resource job application, but there are some significant differences. Required information includes personal/individual information, education (medical/professional school), postgraduate training, licensures and certifications, specialty, work history, references, and hospital affiliations. The provider must provide information regarding malpractice insurance, malpractice claims history, and practice locations and answer a series of disclosure and attestation questions regarding criminal history, malpractice claims history, drug use, and ability to practice in the profession. The medical staff applications also include a request for clinical privileges.

Software – Authorized Users:

Medical Staff Applications should only be sent directly to the LP applicant's email address. Applicants then may choose to authorize another user directly through the software or may submit a written

request for the MSP to send their application to another user to assist in completing their application.

This authorization should include the name, relationship, email address, and phone number of the individual who is being authorized to complete their application on their behalf. This LP-provided authorization must be documented in the provider's MD-Staff profile under the Files section as File Type "Practitioner Provided."

The MSP should alert the applicant in an email that their authorization gives permission to the authorized user to complete their application on their behalf, yet it remains the responsibility of the LP applicant to request privileges and ensure their application is correct and complete.

The "**Sign and Submit**" screen in the current credentialing solution meets the legal requirement for the applicant's attestation and agreement that all information provided is true and accurate and that no material or facts have been omitted that would render the application false, factious, or fraudulent.

When should applications be sent out to the applicants?

After the applicant has accepted the tentative job offer, the pre-application or initial appointment application can be sent to the applicant for an IHS hire. The notice of acceptance of the tentative job offer should come human resources or may come from your clinical director (CD) or chief medical officer (CMO). For contractors, once their profile and CV have been reviewed by your CD or CMO, the initial application or pre-application may be initiated.

For reappointments, it is recommended that applications be sent at least 90 days before the applicant's next appointment date.

Initial Applications

For IHS, initial appointments are one year in length regardless of accrediting body medical staff standards. Only IHS OMB-approved Medical Staff Initial applications shall be used for all initial applicants.

Software - Steps for Sending an Initial Application (and Pre-Application or Credentialing by Proxy (CBP) Intake Form):

For every Initial (Pre-Application and CBP Intake Form), the MSP **must** check to confirm whether the LP is already in the system. Not performing this check correctly can result in a duplicate provider and

presents a potential risk to the agency by missing information about a provider, including past performance.

1. **Initial Check – Do not risk a duplicate provider:**

a) Credentialing > MD-App > New Affiliation and search for the provider by last name (accurate spelling is crucial). **Note**: If the provider has changed their last name, they will not show on this list.
b) **Note**: The Credentialing > Advanced Provider Search only works to identify other LPs if the search is performed at the Global Market level. Do not search with the Advanced Provider Search unless you have Global Market access.
c) Then, if the provider is found, use Step 2 below; if not, use Step 3 below.

2. **If Provider is Found:**

a) Confirm that the provider's name and email are correct and then select the **Application Template**.
b) If using **Aiva Cycles**, select the appropriate cycle.
c) Select the name of the MSP the file will be **assigned to**
d) Add the **Checklist**
e) Check all **General Documents** to include (e.g., Practitioner Acknowledgment & Release and any other facility-type documents that you need to send to the LP)
f) Use the **Privileges** search box to select the electronic privileges to send to your provider. **Note**: Privileges must be set up and published in the system to see them here.
g) Review your selections, scroll back to the top of the page, and click the **Submit** button.
h) It is always best practice to confirm that the application was sent successfully. This can be done simply by clicking on the Applications option found on the left panel. If you do not see your provider's name listed on this page, contact the Support team at 1 (800) 736-7276 for assistance.

3. **If Provider is not found**:

a) Go to **Credentialing > MD-App > New Application Request**
b) Enter the **Last Name, First Name, Middle Name, E-mail, Confirm E-mail, NPI, Aiva Cycle (if using), Assigned To, Checklist**, and any other information, then s**elect the Checklist and Application template**.

c) **Note**: If the LPs **NPI** is unknown, look up the NPI on the NPPES NPI Registry using their name. Confirm that the degree and specialty matches the applicant's details and request the NPI from the applicant, if necessary, for common names.
d) Scroll further down the page and select any **General Documents** (e.g., IHS Conditions of Application and Release Form and any other facility-type documents needed to send to the LP) and the requested privilege form to include with the provider's application.
e) Finally, after double-checking the information, click **Approve**

Note: When the last name and NPI number entered match with an existing provider, a message will appear that the provider already exists in MD-Staff. Completing the "1. Initial Check" above ensures that the provider does not exist in the system and is truly brand new. Select Other Options > Create a New Applicant (not recommended) and proceed.

Reappointments

For IHS, reappointments are two years in length regardless of accrediting body medical staff standards. Only IHS OMB approved Medical Staff Reappointment applications shall be used for all reappointments.

The provider cannot provide patient care services until the practitioner has been approved for their next appointment and privilege cycle.

Software - Steps for sending a reappointment:

1. Navigate to **Credentialing > MD-App > Begin a MD-App Reappointment**
2. The *Select Provider* window will display. Use the **Provider** search box to choose from the existing providers across all facilities and click the **Next** button.
3. After selecting the provider, choose an **Application Template** to send and select from your **General Documents** (e.g., Practitioner Acknowledgment & Release along with any other facility documents) to include with this application packet. *Note: To be available on this page, the documents must be uploaded through Set Up > MD-App > Documents.*
4. Next, select the **privilege form(s)** to be included.

5. Before sending out this application to the provider, scroll to the bottom of this screen to confirm that the privilege form and email address are correct.

What Deems an Application Complete for Importing?

Applications are considered complete when all professional education and practice questions have been answered, and the required information has been provided. This allows the MSP to conduct and complete all verifications necessary to meet agency and local policy, federal regulations, accrediting body standards, and the medical staff bylaws. The MSP review of the application before importing is critical to avoid delays in processing the application and reducing turnaround time. Reconciling discrepancies and ensuring the documentation is accurate will provide the MEC and GB the information they need to make quality decisions.

An application is complete and ready for import when:

1) all the required fields on the application have been completed by the applicant that supports the facility's ability to verify all required policy, legal, accreditation, and medical staff Bylaw elements and allows for current competency to be verified;
2) all professional practice questions have been answered, and responses are provided for questions answered with a yes;
3) all education and training completion and disciplinary action fields have been answered, and responses provided where a response is required;
4) a request for specific privileges is received;
5) a signed IHS Practitioner Acknowledgment & Release is received (required to be able to conduct any verifications);
6) contact information for current peer references is received;
7) contact information for affiliation and work history is received, disciplinary action fields have been answered, and responses provided where a response is required;
8) current malpractice coverage that will cover the LP at IHS (if applicable) that meets or exceeds $1 million individual and $3

million aggregate, that indicates the applicant's name as being covered, and is current is received;

9) any time gaps identified by the applicant since graduation from medical school greater than 30 days include a written explanation (once imported, a Gap Analysis will need to be conducted and analyzed), and;

10) any potential credentialing concerns have been addressed.

Applicants shall be notified by the medical staff professional of missing required information and/or items to determine eligibility for medical staff membership/clinical privileges. The applicant is responsible for furnishing information to help resolve any questions concerning these qualifications. If the applicant does not respond within 30 calendar days of the written request and/or the time specified in the local medical staff bylaws, rules and regulations, or policies, the application (initial or reappointment) is deemed incomplete and ineligible for processing. The applicant will need to re-submit a medical staff application if they are still interested in pursuing appointment and privileging.

Unresponsive Applicants or Late Applications

When a request is made for an LP to provide additional information regarding their application but are non-responsive and there is no time limit specified in the local medical staff governance or polices, the LP has 30 calendar days to be respond. After 30 calendar days, their application is considered incomplete and ineligible for processing.

Software: Application Tools

Pre-Application is a tool designed to assist service units to pre-screen LP applicants. The goal is to identify eligibility according to agency policy and privilege criteria before submitting a full application for medical staff membership and/or privileges. Pre-applications can assist in avoiding unnecessary application denials and the subsequent obligation to report to the National Practitioner Data Bank (NPDB). Pre-application screening includes, but is not limited to, license verifications, queries of the Drug Enforcement Administration (DEA), System for Awards Management (SAM) Excluded Parties List System (EPLS), Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), and an NPDB query.

Any information provided on a pre-application will populate on an initial appointment application in MD-Staff. Pre-applications are not required and is the choice of the service unit to use or not use the Pre-Application.

Software: To send a Pre-Application, follow the steps above in the Initial Application beginning with 1. **Initial Check – Do not risk a duplicate provider**. Following through Step 3, select the **Pre-Application** form for the **Application Type.**

After the Pre-Application is submitted, and should the clinical leadership want to send a full application, the MSP will follow the following process:

1) Navigate to **Credentialing > Existing Appointments > Begin a MD-App Reappointment**.
2) Select **Names** tab
3) Enter provider's name
4) Select **Next**
5) For the **Application Template** select **Initial Application**
6) Select **Facility** or **Facilities** that you are sending the application on behalf.
7) Select what **General Documents** you will send (e.g., Practitioner Acknowledgment & Release and any other facility documents) to include with this application packet. *Note: for the documents to be available on this page, they must be uploaded through Set Up > MD-App > Documents.*
8) Select what **Privileges** you will send to the provider
9) Select the **Assigned User** and the **Checklist**
10) Select **Start**

Credentialing by Proxy (CBP) Intake Form is a tool designed to gather LPs information directly into the software. This tool provides the minimum amount of information needed to maintain, process, and track the CBP telemedicine LPs in the software. For additional guidance on the CBP process in IHS, please see Section 13 of CBP below.

Software: To send a CBP Intake Form, follow the steps above for the Initial Application beginning with 1. **Initial Check – Do not risk a duplicate provider,** and following through Step 3, select the **Credentialing by Proxy** Form for the **Application Type.**

Credentialing Forms

Peer Reference – The IHS Peer Reference Form includes information regarding the LPs medical and clinical knowledge, interpersonal skills, technical skills, clinical judgment, communication skills, ability, and professionalism (ACGME Six Core Competencies). These six core competencies are required for Joint Commission-accredited and CMS-certified facilities. The Peer Reference Form is located in the software and is named "Peer Reference (OMB Approved)."

Peer Reference Software – The IHS Peer Reference is a Pronto survey in the software that allows the peer reference to be emailed to the peer through the software's Peer Reference tab. The software will also track the date it was requested and received. The MSP can send multiple requests. The software will keep track of the number of times the request is sent, the timespan it took the peer to respond, will notify the MSP when the information is received, and identify if there are any negative results. Paper peer references should only be used in rare situations.

The Peer Reference (OMB Approved) Form is used for all peer references and is set up in MD-Staff on a Global level to select and use.

Affiliation – The IHS Affiliation Form includes information regarding the LPs time at their previous place of employment. It is designed to capture information about the LPs time, type of membership, malpractice litigation, clinical practice, and character that assists in assessing the LPs current competency and validates appointment information provided on the application.

Affiliation Software - The IHS Affiliation Form is a Pronto survey in the software that allows the affiliation request to be emailed to the LPs current and/or previous affiliations through the software's Hospitals tab. The software will also track the date it was requested and received; it will continue to send a request, counting the times the request is sent, the timespan it took the affiliation to respond, notify the MSP when the information is received, and identify if there are any negative results. Paper affiliation requests should only be used in rare situations. The Affiliation (OMB Approved) Form is used for all affiliations and is set up in MD-Staff on a Global level to select and use.

Education - The IHS Education Verification Form includes information to confirm the LPs medical degrees, specialty training, and completion of residency and fellowship programs. It is designed to capture

information regarding the LPs time, completion status, clinical practice, disciplinary actions, and character to assist in validation of their education and training, assessment the LPs competency, and confirmation of information provided on the application.

Most education or training programs provide primary source verifications through either the American Medical Association (AMA), the American Osteopathic Association (AOA) profile or the National Student Clearinghouse (NSC). If verifications are unavailable through these sources, the MSP should verify directly with the programs.

Education Software - The IHS Education Form is a Pronto survey in the software that allows the education verification request to be sent by email to the LPs current and/or previous education and training programs, and is available through the software's Education/Training tab. The software will also track the date it was requested and received; it will continue to send a request, counting the times the request is sent, the timespan it took the university or program to respond, notify the MSP when the information is received, and identify if there are any negative results. Paper education and training requests should only be used in rare situations. The OMB approved Education/Training Verification Form is used for all education and training verifications and is set up in MD-Staff on a Global level to select and use.

Insurance - The IHS Insurance Verification Form includes information to confirm the LPs current and previous medical malpractice coverage and claims history. It is designed to capture information regarding the LPs malpractice coverage and assess the LPs open/pending claims and settlements information provided on the application. Insurance verifications can be difficult to obtain from insurance companies and verification of past insurance coverage should not hold up a credentialing file for review. IHS utilizes the NPDB to verify an applicant's complete medical malpractice history and ascertain the background, status, and nature of any malpractice cases associated with the applicant. The open/pending malpractice cases are disclosed on the LPs application.

Insurance Software – The MD-Staff Insurance tab does not allow for Pronto verifications through the software. To verify the current insurance covering the provider, the MSP will need to complete a Merge Package and email or fax the request to the Insurance company.

1. Navigate to **Merge/Pronto**

2. Select **Demographic**
3. Click on Select **Names**
4. Enter the **Name** of the Provider
5. Click **Next**
6. Select **Package** and select the Insurance Verification (Global)
7. For **Send Via: Select View/Print**
8. For **Output: Select Adobe PDF or Word**
9. Keep the **Log Activity** box checked
10. Select **Merge**, once the download bar is 100%, select Download. The download will be in the Download bar at the top and/or you will receive a message in your MD-Staff Inbox titled **Mail Merge Complete** and a download button, or navigate to Merged Documents and download the document.
11. **Save** the PDF/Word document and email or fax it to the insurance company.

The Insurance (OMB Approved) Form is used for all insurance verifications and is set up in MD-Staff on a Global level to select and use.

Provider Release Form - The IHS Conditions of Application and Release Form is an important form for credentialing and privileging. A signed release form from the LP is required to begin requesting verifications.

The first page of the release provides conditions for which the LP can be held while the application is being considered and processed, and as a condition of continued appointment.

The second page of the form is a two-way release allowing IHS to request, obtain, and disclose information on an LP to/from the IHS to credential and privilege at an IHS facility. The bottom of page two and three of the release include the OMB Burden Statement and the Privacy Act Statement.

Provider Release Software:

The signed release form is filed in the Files section under the File Type "Statement of Release." The release can then be attached to Pronto verifications for peer references, affiliations, education/training, insurance, and other verifications.

Setting up a Bundle for Pronto Verifications in MD-Staff

To set up the Peer Reference, Affiliation, Education, or Insurance forms in MD-Staff for Pronto Verifications, navigate to Set Up > Files > Document Bundles. Select Add. Enter a Bundle Name. Select the Message Template. Select the appropriate form (OMB Approved) from the available Prontos and select Statement of Release from the available provider file types. Click Save.

> *If there is not a Message Template available or need to edit a current facility-specific one, go to Setup > Administrative > Message Templates, and search for the template to edit and/or add and create one. Add merge fields to the message template. Message templates are facility-specific. The Module type is Verification.*

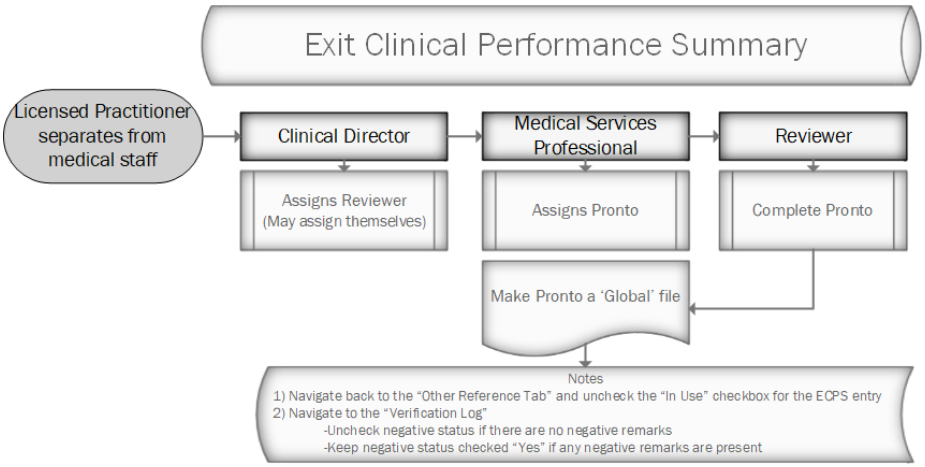
The document bundle is set up and ready to use in the associated tab in MD-Staff. For further guidance utilize the MD-Staff online guides, and on-demand videos, or call Support at 1-800-736-7276.

Exit Clinical Performance Summary (ECPS) is an internal IHS document completed when a provider resigns or employment is terminated at a federal IHS facility. It serves to provide a factual real-time record of the provider's clinical performance and professional conduct at the time the LP leaves the facility. Capturing this information in a timely manner assists the CD/CMO or department chair in not having to try to recall (sometimes years later) how the practitioner performed. Similar to a Forever/Evergreen Letter, the ECPS allows any IHS facility that a provider may apply to in the future review their clinical and behavioral performance at that time. This summary is important as it ensures continuity and transparency in the credentialing process, supporting high standards of patient care. The document includes essential information such as the provider's personal details, employment dates, clinical competence, quality of care provided, professional conduct, and final recommendations. The form is completed by a peer or supervisor, as assigned by the clinical director.

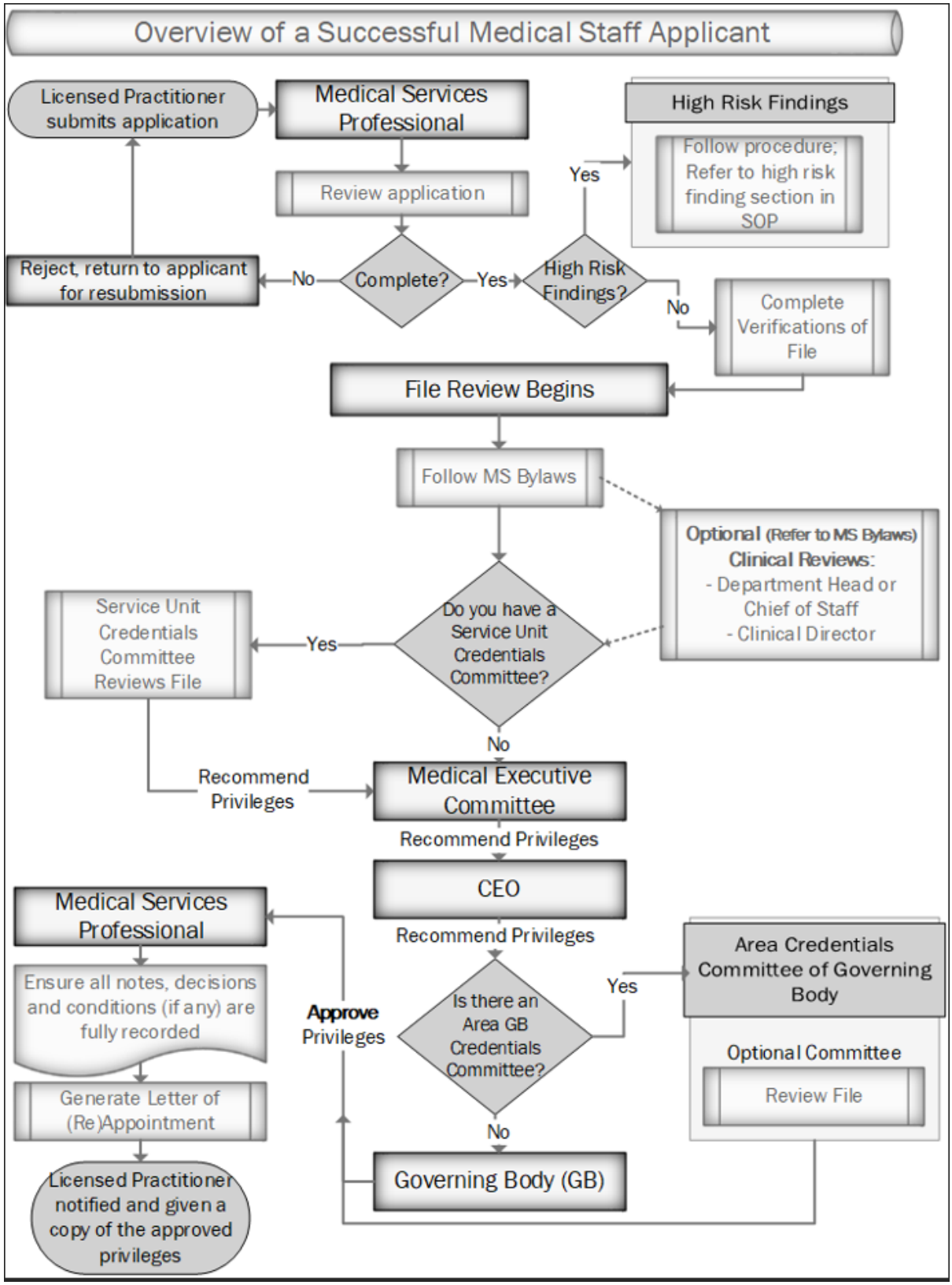
Software – Exit Clinical Performance Summary

See Job Aid in the Appendix.

Below is a short process map detailing the steps of an ECPS:



The following process map aims to outline an overview of a successful medical staff applicant in the IHS.



Section 6: Verifications and Processes

Credentialing and privileging processes are two MSP primary functions within the IHS. The credentialing process involves obtaining evidence of qualifications to verify that an applicant has obtained the necessary experience, training, and authority to practice within the privileges requested.

The following section identifies minimum requirements for verifications and processing of initial, reappointment, and credentialing by proxy applicants and provides instructions, administrative requirements, verifications, and processes.

General Information:

All LPs who provide patient care at IHS facilities must submit verifiable evidence of and maintain current, active, and unrestricted licensure, registration, certification, current competence, and/or credentials, and prove proficiency in their granted privileges following applicable law, accreditation standards, the IHM 3-1 Credentialing and Privileging policy, this SOP Manual, privilege criteria, and conditions of employment.

The process for granting medical staff membership and/or clinical privileges is applied uniformly and objectively to all applicants.

IHS areas and service units may choose to have more stringent verifications and processes compared to the SOP and IHM 3-1 Policy, but may not have less stringent verification requirements.

Administrative Requirements Verification and Processes:

Credentialing ensures an applicant meets the minimum required licensure, current competency, character, training, education, and judgment to fulfill the position requirements and support any requested clinical privileges. This section contains the administrative requirements for verifications and procedures related to the initial credentialing, reappraisal, and credentialing by proxy of LPs who plan to apply for clinical privileges.

(1) Primary source verifications are required for all credentialing information submitted by an LP. When online prime source verifications do not document the date the verification was produced/searched, the MSP electronically signs and dates the verification to illustrate when it was processed.

(2) There must be a follow-up of any primary source verification discrepancy found during the application and verification processes. The practitioner has the right to correct any information with a written and signed response and verified by the MSP whenever possible. The practitioner is required to follow up with the verifying entity, if necessary, to determine the reason for the discrepancy. The burden of proof is on the applicant to provide all necessary verifiable information to support their application and to conduct required verifications. The primary source verification of expirable credentials must be current and cannot be greater than 120 days old (or if a lesser timeframe is identified in the facility's bylaws or policy) at the time the credentials and privilege file is submitted to GB for review.

(3) MSPs who are also individual purchase card holders may use IHS-issued purchase cards within the Agency's current credentialing software to optimize use of the system, assist in timely on-boarding of practitioners, therefore, supporting the mission of the IHS. Use of IHS-issued individual purchase cards must comply with the IHS Credentialing and Program Government Purchase Card Use with the IHS CEP-MDS processes located in the IHS Clinical Staff Credential and Privileging Guide (Appendix).

(4) When a required verification cannot be obtained after three attempts, the MSP documents who they attempted to verify with, the date of request, and verification methods. This is included in the Notes section of where the verification is located.

(5) Each area/service unit must set alarms and monitor all credentialing and privileging expirables to ensure compliance (e.g. reappointment of credentialing files, licenses, registrations, certifications, board eligibility and certification, NPDB, and insurance) in the credentialing software. All expirable credentials should have automated scheduled messages set up to alert the provider prior to when a credential expires. During any credentialing software disruptions, the service unit shall maintain ongoing verifications of credentials by completing primary source verification outside of the credentialing

software, then update fields and upload verifications in MD-Staff once the software is available.

Types of Verifications

Verification of credentials must be achieved through primary and/or designated equivalent sources. If using primary or designated equivalent source verifications are feasible, such as when an education institution or residency program has closed, secondary sources may be used if the primary source no longer exists, or a designated equivalent source is not available. This process should only be used on rare occasions and follow the accrediting standards and policies of the facility. Please note that utilizing secondary sources may not be acceptable by some accrediting bodies.

Copies of a diploma, license, registration, etc., in place of evidence of completing primary source verification are not acceptable verifications.

Acceptable verification types include:

Primary Source Verifications: Refers to the validation of credentials and other information provided by the applicant, with the original issuing entity (primary) sources of the credential (e.g. communicating directly with a medical school to confirm that the applicant attended and graduated.)

Designated Equivalent Source (DES) Verifications: Verification through approved entities that verify credential data through the primary source. Approved designated equivalency sources can vary, depending on the accrediting organization. For example, The Joint Commission lists the AMA Physician Profile as a designated equivalent source for verifying medical education.

Secondary Source Verifications: These refer to verifications that do not originate from the issuing entity/organization or a designated equivalent source and should rarely be used. A secondary source verification is a verification conducted by a reliable secondary source, such as another hospital that has documented primary source verification of the credential.

Tip: In rare occasions where a primary or secondary source verification cannot be obtained, the MSP should contact the applicant's recent affiliations to discover how they were able to obtain the verification. If an affiliation has a primary source verification of the credential, the

MSP should provide the applicant's signed release and request a copy of the verification.

Verifications and Procedures

This section contains the minimum requirements and procedures related to the initial credentialing and reappointment of LPs who plan to apply for clinical privileges at an IHS facility. Areas and service units may choose to have more stringent verification processes but may not have less stringent verification requirements. Any unfavorable findings in the verification process, including time gaps, are identified and reported to the medical staff to consider in their recommendations and credentialing decisions. Applicants should also submit written explanations upon submission of the application relating to any instances of discipline, suspension, probation, or reprimand identified on the application or through the verification processes.

MD-Staff allows for checklist templates to be created and used. Checklists optimize the use of documenting complete applications.

Software: **Duplicate entries**

The Hospitals, Education/Training, Other References, Peer References, License/Credentials, Board Certifications, Specialties, Insurance, and Medical History are all shared tabs in MD-Staff for providers affiliated at multiple facilities. If duplicate entries are found, verify which entry is correct by comparing it to the verification and contact the other active affiliated sites to discuss deleting the duplicate entries. As a note, records from the verification log attached to these shared tabs remain in the verification log, even if the duplicate entry in the tab is deleted. Each entry only needs to be displayed one time.

Software: Latest Verification

In MD-Staff, the following shared provider tabs: **Hospitals, Education/Training, Other References, Peer References, Licenses/Credentials, Board Certifications, and Insurance** allow for documentation of manual and automated copies of verifications to be attached to the entry in the provider profile.

Latest Verification:

If the verification was completed outside of MD-Staff, manually add the verification information and file, if applicable. In one of the provider

tabs identified above, the verification information can be added in the **Latest Verification** section for each entry**.**

Click on the record you want to add the verification. In the **Verified By** section, click on **Add Verification** under Latest Verification at the bottom of the screen.

- **Date Requested:** The day the verification was requested.
- **Method:** How the verification was received. For example: Website, Email, Fax.
- **Date Received:** The day the verification was received.
- **Negative:** If any information on the verification is negative, click on the box next to this field.
- **Comments:** Add notes, reminders, comments, etc. in this field.
- **Save**
- The system will prompt the attachment of a file to this verification. If applicable, select **Click Here** to load a file such as a scanned document; otherwise, click **Close**.
- The manually added verification can be found in the **Verification Log** and will also be added to the **Verified By** section.

Quick Tip: When verifying an item on a website, it is not necessary to print the web page and then scan the copy. Your web browser has a 'Save As' function to save a capture of the web page as an MHT file type. Save an MHT capture to a temporary location and attach that file to the verification. However, MHT file types cannot be seen in Virtual Committee. To be seen in Virtual Committee, you need to save it as a PDF.

Note- Verifications can be edited on the Verification Log screen.

Software – Attach a Record

In MD-Staff the following shared provider tabs: **Hospitals, Education/Training, Other References, Peer References, Licenses/Credentials, Board Certifications, and Insurance** allow for files uploaded in the Files tab to be attached in the provider file.

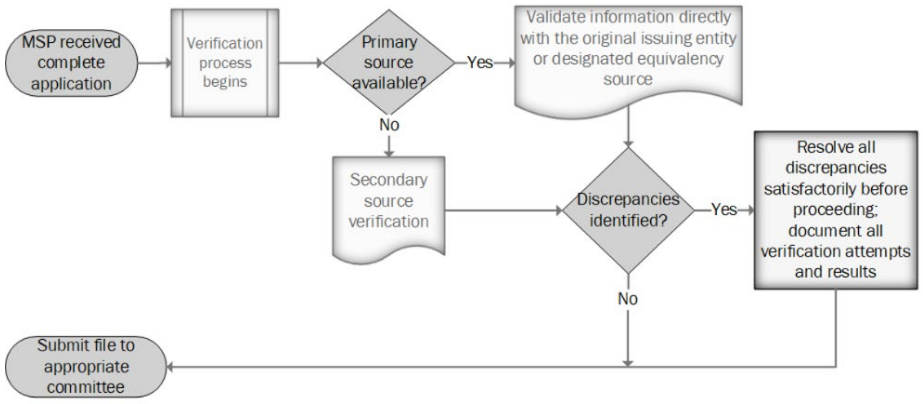
Attach a Record: A record (file) can be attached to a provider's profile. This is useful for files associated with E>Priv displays for clinical leadership. In one of the tabs identified above, a copy of the file or verification for each entry can be added**.**

To attach a record (file) from the **Files** to the Hospitals or Other References section, the file must be uploaded in the **Files** tab. The verification may need to be downloaded from the **Verification Log** and saved in the Files tab because the Verification Log is not linked to the Files tab.

- Navigate to the **Files** Tab of the provider record.
- Select the **File** you want to attach to an entry in the **Hospitals or Other References** tabs. If the File is not uploaded here, you will need to **Add** and **Save** it first.
- Under the **Attached Record** section at the bottom.
- Select the **Record Type**: Choose the Record Type, which is the corresponding tab where the entry is located. As an example, for a hospital verification file in the Files section's corresponding tab is **Hospital; and** a military verification file in the Files section's corresponding tab is **Military**. Select **Name >** Select the corresponding entry of that record and **Save**. If a corresponding tab in Hospitals or Other References is not visible, add the entry in the tab before linking a record in the Files tab.

Verifications

The following process map outlines where verifications begins and ends:



The following verification of documentation corresponds with the minimum requirements listed in the IHM 3-1.5 Medical Staff Credentials "A. Verification of Documentation." This verifications section is structured in the following format:

1) Verification Element
2) Standard Work Element
3) Acceptable Verifications
4) Software Processes

The credentials review process for clinical privileges shall, at a minimum, require collection, analysis, and verification of the following documentation/information:

(1) Proof of Identity

It is important to verify that the LP identified in the credentialing documents is the same person presenting to provide patient care. Some accrediting bodies require the identity verification as a security measure because there are multiple accounts of identity theft and individuals posing as medical providers.

The MSP should obtain a recent photograph of the LP and upload it in the LP file in the Demographic tab. This is important to E>Priv Displays so staff can verify that the person presenting to provide services is the same person who has gone through the credentialing and privileging process.

Copies of the LPs driver's license, social security card, passport, and other photo identification should not be kept in the credentialing software.

Standard Work Element - Proof of Identity

At Initial Appointment, the LPs identity is verified before the LP provides patient care by viewing a current state-issued driver's license, passport, or military ID. The verification is documented on the IHS ID Attestation Form. Identification attestations should not be shared among facilities unless the area has a centralized credentialing office. For LPs who are fully credentialed and privileged at the facility and who never present onsite where the patient is located, applicant identity verification is completed via the use of a telecommunications link that includes both audio and video.

For facilities that execute the credentialing by proxy (CBP) method for telehealth providers, identification verification is the distant site's obligation. Identification verification responsibilities may be delineated in the agency's CBP agreement.

Identification verification is not required for reappointments.

Acceptable Verifications – Proof of Identity
A state-issued driver's license, a passport, government-issued personal identity verification (PIV), or military ID that is not expired is an acceptable proof of identity. Picture Hospital ID Cards can be utilized with disaster privileges if a state-issued driver's license, a passport, or military ID is unavailable.

Software – Proof of Identity
Upload the IHS ID Attestation Form in the LPs Files as Type "Identification" set to the facility.

(2) Professional Education and Post-Graduate Training
The LPs accompanying application shall include a complete list (domestic and foreign) of the names of medical schools or professional schools, dates of attendance/graduation/ completion, location, type of degree, and any disciplinary actions.

LPs subject to the medical staff credentialing and privileging process must possess a valid diploma certifying them as a graduate of a professional school, accredited by a nationally recognized accrediting body appropriate to the LPs professional discipline.

- Medical Degree
- Post Graduate Training (Internship, Residency, & Fellowship)
- Foreign Medical Education Graduates

It is important to note that obtaining a degree and postgraduate training does not automatically confer a license to practice medicine.

Medical Degree and Post-Graduate Training
Professional education is the level of education that is the qualifying degree for the profession. For all LPs, enrollment in any portion of a professional education or training program (even if incomplete) must be reported and verified. Any withdraws or leaves of absence (voluntary or involuntary) and disciplinary actions (suspensions, expelled, dismissed, probation, etc.) must be explained in the professional practice questions on the application and verified.

Foreign Medical Education Graduates
The Education Commission for Foreign Medical Graduates (ECFMG) and its organizational members define an International Medical Graduate (IMG) as a physician who has received his/her basic medical degree or qualification from a foreign medical school. The location of the foreign medical school, not the citizenship of the physician, determines whether the graduate is an IMG. This means that U.S. citizens who graduated from foreign medical schools abroad are considered IMGs and would require ECFMG certification. Non-U.S. citizens who graduated from U.S., Puerto Rico, or Canadian medical schools are not considered IMGs and would not require an ECFMG certification.

Certification by ECFMG is the standard for evaluating the equivalence of educational qualifications of these physicians before they enter U.S. graduate medical education, and ECFMG certification is required to obtain an unrestricted license to practice medicine in most U.S. states.

Standard Work Element: Education/Training
At initial appointment, the MSP shall verify the applicant's complete list (domestic and foreign) of medical schools or professional schools attended and any post-graduate training, such as internship, residency, fellowship, or other organized professional training.

At reappointment, any current or new education or post-graduate training must be verified.

Acceptable Verifications – Education/Training
Facilities may use the AMA, AOA, ECFMG, FSMB, NSC, the college/university or program, training schools or residency training programs, state medical boards, and any other designated primary sources to verify medical or professional education and training. If primary source verification is conducted directly with the school or program, the OMB-approved IHS Education Training Verification Form or pronto must be used.

Verifications received directly from the applicant cannot be used. Medical education and training must be verified with a primary source or designated equivalent source.

Software – Education/Training
All types of education and training, including ECFMG, are maintained in the Education/Training tab of the provider's file. Any primary source verification related to education and training is documented in the Verification Log or the Education/Training section of the provider's record in MD-Staff.

<u>Education/Training Tab</u>
Type (of Education):

- **Undergraduate** - education completed for an associate or bachelor's degree.
- **Graduate School** - education completed for a master's degree or sometimes a doctorate (i.e. PhD.)
- **Medical Education** - education completed for a medical practitioner (MD/DO).
- **Internship** – the first year of training after medical school, also known as PGY-1 (Post-Graduate Year-1).
- **Residency** – The years following internship, from PGY-2 onward.
- **Fellowship** - Specialized training in a particular area of medicine after completing residency.

Degree:

Enter the type of degree awarded – Associate, Bachelor, Master, or Doctor

- If no degree was earned, choose "No Degree." If the entry is for a residency or internship, leave it blank.

Subject:

- Field of study or concentration focus during education

For primary source verifications conducted directly with the university, college, or post-graduate training programs, the OMB-approved IHS Education Verification Form is used and set to Global in the software for sharing.

For designated equivalent source verifications conducted with AMA, AOA, or ECFMG, these organizations do not permit sharing per their terms of use and verifications are set to the facility in the software, unless the area is set up as a centralized credentialing office.

(3) Experience (Hospitals and Other References)

MSPs should compare and reconcile a provider's experience and practice history, as well as dates disclosed by the provider versus dates verified. An applicant must provide a written explanation for any time gap greater than 30 days since completing medical/professional school. If discrepancies exist, the applicant must provide a written explanation or be offered the opportunity to amend the submitted application. Reconciliation of practice history timelines may lead to additional affiliations and employment history verifications. MSPs should confirm the practitioner's professional practice history, with all gaps explained, instead of entirely relying only on what the applicant voluntarily reports.

- **Affiliations** are places where the LP has/had privileges and may have been members of a facility's medical staff. This complete summary of practice history and affiliations in which an LP has worked or held clinical privileges (e.g.

academic appointments, hospitals, practice groups, surgery centers, etc.) must include dates of affiliation or work history, locations, the reason for leaving, any disciplinary actions, and facility contact information. Additional information may include title/professional occupation or medical staff memberships held, types of clinical activities or privileges, and verification of status or standing.

- **Employment** is a list of other places an LP has worked but did not hold privileges or have been a member of a facility's medical staff. The list should include any full-time, part-time, temporary, and volunteer positions. Employment should include job titles, company names, duration of employment, supervisor names contact information, and the reason for leaving.
- **Teaching** is a list of professional places where the LP has held a teaching position. Include source and dates.
- **Military** is a list of military assignments. Similar to education and training history, verifying an applicant's military experience provides insight into an applicant's work history and overall professional competency. Include source and dates.
- **Gap** is a time period greater than 30 days in an applicant's training or experience since graduation from medical/ professional school. Include dates.
- **Other** is all other types of experience that do not fit in the above categories. Include source and dates.

Standard Work Element: Experience (Hospitals/Other References)

On the initial application or through documentation on their CV, applicants must account for all time since graduation from medical school. Any gaps greater than 30 days since graduation from medical/professional school must be documented in MD-Staff.

At initial appointment, MSPs should at a minimum verify current, relevant experience (affiliations, work history, and military) for at least the most recent 5 years for work history **and** the most recent 5 years for affiliation history – or as far back as necessary per any conflicting information or suspicious indicators, to assess current competency.

For reappointments, all current and/or active affiliations since the last appointment shall be verified to ensure good standing.

Acceptable Verifications – Experience (Hospitals/Other References)
For primary source verified employment history and/or affiliations, the OMB-approved IHS Affiliation Verification Form must be used. However, work history, affiliation, and active military service verification requests may be returned from employment sources without answering all the questions because they are not relevant to the position, e.g., privileges, medical staff. This is acceptable.

Affiliation verifications are attempted at least three times. It may be necessary to contact the applicant to ensure the contact information provided is correct. It is appropriate to request that the applicant reach out to the affiliation and request that they complete the verification form. Document all affiliation verification checks, including responses and any follow-up actions taken in the LPs credential file.

A DD-214, for discharged individuals, can provide details on specialty, records of service, and dates of assignments and is considered a prime source verification by NAMSS and IHS.

Software – Hospitals
Affiliations are stored in the Hospitals tab in MD-Staff.
Add all hospital affiliations where the provider has or had medical staff privileges and/or membership. Any primary source verification is documented here through Add a Verification.

- **Subject**: list Position, title, focus of work during, or subject studied. Enter the **Source** and **dates** of affiliation.

Software – Other References
Add all employment, teaching, military, gaps in employment, or other work history, as required. This includes work experience NOT associated with affiliations where the provider has or had medical staff privileges and/or membership. Any primary source verification is documented here through Add a Verification.

- **Subject**: list Position, title, focus of work during, or subject studied. Enter the **Source** and **dates** of association.

(4) Time Gaps

A time gap is a gap greater than 30 days since graduation from medical/professional school where an applicant was not in school or training, in the military, teaching, working, or volunteering. Explanations of these gaps, or lack thereof, may provide insight into an applicant's past that may be critical to the credentialing decision/recommendation.

Standard Work Element – Time Gaps

On initial appointment, any time gaps greater than 30 days since graduation from medical/professional school shall be identified and explained on the initial application and in the current credentialing software. There will be no unexplained or unaccounted time gaps of 31 days or more.

Acceptable Verifications – Time Gaps

May include, but should not be limited to, state regulation, applicable professional and training schools or residency training programs, NSC, AMA, AOA, ECFMG, FSMB, state medical boards, and applicant explanations and disclosure on the application.

Software – Time Gaps

Gaps identified by the provider are recorded in the **Other References** tab as **Type: Gap**

Each LP should have a **Gap Report** completed and assessed at the time of the Initial Appointment.

- Navigate to **Credentialing > Reports > Gap Report**
- Select the **Names** tab and enter the provider's name
- Select **Run**
- Save file in a PDF and assess for gaps
- File in the provider's **Files** tab under **Type: Gap Report**

Note: Gap Report ties to entries on Education/Training and Other References tabs.

Tip: If there are gaps, but the LP did not provide any gaps or explanations on the application, compare the application and CV

with what is in the software to ensure nothing is missing. If there are gaps, the provider will need to be contacted for a written explanation.

(5) Board Certification and Professional Affiliations

Applicants should submit a complete list of board certifications held, including certification number, original dates, recertification dates, and participation in Maintenance of Certification, if applicable. MSPs will check the facility's privilege criteria and conditions of employment (for HIS employees, review the position description, and for contractors, review the contract) to determine if the LP meets the board certified/board eligible requirements and alert the facility's clinical leadership of any discrepancies. It is the responsibility of the facility's clinical leadership to ensure that the provider's board certified or board eligibility aligns with the privileges being requested and services to be provided.

Standard Work Element - Board Certification and Professional Affiliations

Each LP (IHS employee, tribal, contractor, volunteer) who is a licensed MD or DO must either be board eligible or board certified (BC/BE) Any LPs working in the IHS without BE/BC appointed before **10/01/2026** are exempt this requirement as long as they remain in good standing, as noted on ongoing peer review and any exit clinical performance summary (ECPS). "Board Eligible" applies only to the time before the initial certification in a specialty or subspecialty, typically ranging from 3-7 years, depending on the member board requirement.

For applicants that are not BE, BC, or historically exempt from this requirement per the above clause, requests for appointment and privileges are processed as per high-risk credentialing findings in this SOP Manual.

Advanced practice registered nurses (APRN) and physician assistants are required to hold board certification and maintain that certification throughout their employment with the IHS. Additional information can be found in Chapter 4 Nursing and Chapter 28 Physician Assistant of the Indian Health Manual.

Board certifications are verified at the initial appointment and upon expiration. It is not necessary to verify board certification at reappointments unless it coincides with the certification's expiration date.

Acceptable Verifications - Board Certification and Professional Affiliations

Primary sources for verification can include responses directly from the board or display agents, such as American Board of Medical Specialties (ABMS) Certifacts, AMA, and AOA. Additional recognized sources include the American Board of Physician Specialties (ABPS), AOA, American Nurses Credentialing Center, National Commission on Certification of Physician Assistants, Board of Pharmacy Specialties (BPS), or other nationally recognized certifying body.

Software – Board Certifications

All board certifications currently or previously held are documented in the **Board Certifications** Tab in the software. Any primary source verification is documented through **Add a Verification**. Note: this does NOT include state licenses to practice; these are documented in the "License/Credentials" section.

- **Board** is the name of the certifying Board.
- **Specialty** is the Specialty the board certifies.
- **Certified In** is a Sub specialization of that Board.
- **Cert. Number** is the Board Certification number.
- **Exam Date** is the date the Exam was taken or is scheduled to be taken.
- **Initial Date** is the date the board certification was initially awarded.
- **Expiration Date** is the date the board certification expires or the date the board eligibility expires.
- **Status** is the provider's current status with the Board. Lifetime is whether or not the board certification is a lifetime certificate (if so, the expired field does not need to be populated).
- **Maintenance of Certification** indicates if the board certification is within the Maintenance of Certification program.

- **Re-verify** is the recommended date that a lifetime certification needs to be re-verifed if listed.
- **Primary** indicates that the board certification is the primary board certification for the provider.

Navigate to the **Files** Tab to attach a saved copy of the verification from the Files tab. Select the corresponding file in the **File > Edit >** Select the corresponding record **Type**: Board Certification > Select **Name** of Board Certification > Save.

Board Certification/Eligibility Internal Controls:
Board Certification/Board Eligibility compliance is monitored using the following software fields.

For Board Certification, compliance is monitored using the following software fields:

Demographic tab: Degree and Field of Licensure; and
Board Certifications tab: Board, Specialty, Certified In, Certification Number, Initial Date, Expiration Date, Status, Lifetime, and Maintenance of Certification

For Board Eligible, compliance is monitored using the following software fields:

Board Certifications tab: Board, Specialty, Exam Date, Expires, and Status = Board Eligible. Once the MSP has identified when the Board Eligibility expires with the Board include that date in the Expires field. Once the LP becomes Board Certified, the MSP should update the fields for Board Certification.

(6) Licensure

An applicant must submit a complete list of all independently held professional licenses (active and inactive) and registrations, which should include the issuing state, license type, and license number. Additional information may include status, issue, and expiration dates. Licenses allow providers to practice within the scope of each license held. However, the facility can restrict this scope.

MSPs should investigate surrendered licenses or license sanctions, restrictions, revocations, suspensions, reprimands, or probations with the licensing entity and the National Practitioner Data Bank (NPDB.) Applicants must identify any instances of discipline, suspension, probation, or reprimand and submit a written explanation with their application.

Standard Work Element – Licensure
Every LP who provides patient care in federal facilities must possess a current, active, full, and unrestricted license or registration from a State, the District of Columbia, the Commonwealth of Puerto Rico, or a territory of the United States.

At the initial appointment, the MSP will verify and document an applicant's complete list (active and inactive) of professional medical licenses by contacting either the Federation of State Medical Boards (FSMB) or each state licensing board.

At reappointment, the MSP will verify all active licenses or licenses that have become inactive after the initial appointment or since last appointment.

Acceptable Verifications – Licensure
Each facility is responsible for conducting license verifications at the initial appointment, reappointment, and license expiration, and at any time new privileges are requested. License verifications are not shared among facilities unless the area is set up as a centralized credentialing organization. Primary sources for medical licenses are state licensing boards. The Federation of State Medical Boards (FSMB) is a designated equivalent source.

Software – Licensure
Add all current and prior, active, and inactive state licenses in the License/Credential section of the provider file. Duplicate entries are not allowed (see Duplicate Entries section above.)

Any primary source verification is documented either through the **Verification Log** (preferred) or in the License/Credentials section through **Add a Verification** (manually).

Each active and inactive license shall be documented in the LPs profile in the current software and labeled accordingly:

- **Licensure Board**: Name of Licensing Board
- **License Type:** "State License" for current/active licenses, "Inactive State License" for expired licenses.
- **License Number**: License number assigned by the Licensure Board
- **State:** State the provider was licensed in
- **Limitations**: Are there any limitations on this license for the provider
- **Comments**: Comments regarding the license
- **Issued:** Date the license was issued
- **Expired**: Date the license expires
- **Status**: License status
- **Document**: Merge the document associated with the license
- **In Use**: Determines if the license is still in use or not (check for In Use and Uncheck for inactive licenses). This is an important distinction for internal control reports and alarms for verifications.

Licenses/Credentials Internal Control – State licenses are a source of internal control reports monitored for compliance using the following software fields in the Licenses/Credentials tab: License Type, Expired, and License Sub Type (for Nurses only).

(7) **Drug Enforcement Administration (DEA) Registration and State Department of Public Safety (DPS) and Controlled Dangerous Substance (CDS) Certifications**

An applicant must provide a complete list of current DEA, DPS, and/or CDS certificates held and the corresponding registration number. Additional information may include issuing state, status, issue, and expiration dates. Applicants must identify any instances of discipline, suspension, probation, or reprimand and submit a written explanation with the application.

Standard Work Element – DEA, DPS, and CDS

Each facility is responsible for conducting registration and certification verifications at an initial appointment, reappointment, and registration/certification expiration.

Acceptable Verifications – DEA, DPS, and CDS
MSPs shall primary source verify any current DEA through the DEA website, and verify DPS and/or CDS through the appropriate state websites.

Software – DEA, DPS, and CDS
See Software – Licensure above in Item 5 above.

(8) Current Competency

All LPs who provide patient care at IHS facilities must provide verifiable evidence of and maintain current competence. Current competency may be documented through multiple sources identified in this SOP, such as, but not limited to, education, training, affiliations, peer references, and licensure.

Standard Work Element – Current Competency
Current competency as noted in the IHM 3-1.2 D, E.(6), F is determined by clinical leadership, not the MSP.

Acceptable Verifications – Current Competency
Verification of current competence involves obtaining assessments, references, and evaluations from all sources with firsthand knowledge of the applicant LPs current (within two years) competency, character, clinical ability, and technical skills. This may include, but is not limited to, feedback from peers, supervisors, other health care professionals, and organizations who have directly observed the LPs work. This may also include the successful completion of relevant education, training, courses, etc. These verifications ensure a comprehensive assessment of the LPs proficiency.

After privileges are approved, the LPs competence is further confirmed through a Focused Professional Practice Evaluation (FPPE), which systematically evaluates performance in specific areas of practice to ensure that the LP meets the required standards of care.

Software – Current Competency
Current competency is documented in multiple locations in the software.

(9) IHS Conditions of Application and Release

The IHS Conditions of Application and Release Form is an essential document required by IHS for all LPs seeking credentialing and privileging to provide patient care at an IHS federal facility or program. This form authorizes IHS and its representatives to inquire about the LP's professional competence, character, judgment, education, training, and licensure qualifications from other individuals and organizations outside of IHS.

Standard Work Element – IHS Conditions of Application and Release
LPs must complete and sign this form, affirming that all information provided is accurate and consent to the release and verification of their credentials. Electronic signatures are acceptable.

Acceptable Verification – IHS Conditions of Application and Release
The MSP verifies the signature and date of release.

Software – Form is filed in the provider's file as Statement of Release in the Files section as Global.

(10) **Continuing Medical Education (CME) or Continuing Professional Education (CPE)**

Standard Work Element - Documentation of CME or the profession's equivalent continuing education is provided at the initial appointment for the previous two years, unless the LP has completed a post-graduate training in the previous two years. For reappointment and at any time specified in local medical staff bylaws or accrediting body requirements, continuing education is provided since the last appointment. Local medical

staff bylaws may specify a requirement relative to clinical privileges granted or may follow state licensure recommendations for continuing education hours.

Acceptable Verifications – Copies of certificates, summary logs, provider attestation, or other forms of continuing education records.

Software - A copy of the log, summary, or certificates is saved in the LPs credential profile as File Type: Continuing Education and marked as Global.

(11) Professional Peer References

Professional Peer References include information regarding the LPs medical and clinical knowledge, interpersonal skills, technical skills, clinical judgment, communication skills, ability, and professionalism (ACGME Six Core Competencies).

Standard Work Element - Peer Reference Requirements

Initial Appointments: The IHS policy requires collection two peer references for initial appointments. The accrediting body, medical staff bylaws, or area/service unit policies may require more, but not less. It is highly recommended that one reference be obtained from the training program director, department chair, or chief for applicants who are recently out of training programs.

Reappointments: The IHS policy does not require peer references for reappointments. However, the facility should follow their accrediting body, medical staff bylaws, or area/service unit policies for the number of peer references required at reappointment. For facilities that have difficulty complying with a discipline-specific peer, it is recommended to find another provider in IHS with similar credentials to conduct chart reviews and then complete the peer reference. However, peer references are often used at reappointment to help establish a provider's current competency to support the peer review process.

Acceptable Verification - Peer Reference Requirements
The facility should follow their accrediting body's definition of a peer. In the absence of a peer definition, the IHS definition of a peer includes a practitioner in the same discipline or like license/like function. To provide a recommendation, the peer must be familiar with the individual's actual performance. This could be someone within the same organization, a different service unit, or someone from outside the organization. A peer must not be a relative, spouse, or partner. All references are from a professional authority who has worked directly with the applicant within the past two years and can authoritatively speak to the applicant's character, clinical experience, and competency.

Possible Red Flags:

Handling of Negative Feedback: In the event of negative comments received from references, maintain a record that thoroughly explains the context and reasons behind such remarks, ensuring the medical staff finds the explanation satisfactory. If necessary, the clinical director, or equivalent, may need to engage in follow-up discussions with the peer or applicant to better understand the feedback provided.

Handling of Non-Responsive Peers: Reference checks are attempted at least three times. It may be necessary to ask the applicant to contact the listed reference to request that the reference complete the peer reference form and ensure the contact information provided is correct. Document all reference checks, including responses and any follow-up actions taken in the LP's credential file. It may be necessary for the applicant to provide additional references outside of what was provided on the initial application.

Peer Reference Requirements - Software
Once the application is imported, review the Peer Reference Tab to ensure multiple entries of the same peer are not duplicated.

Note: CMO/CD and other LPs in leadership roles who are credentialed and privileged through the software **and** have MD-

Staff CMO/CD access should not have their completed Peer Reference forms attached from their Files to their Peer Reference Tab. This ensures that the LPs providing the peer references are protected and remain confidential.

(12) National Practitioner Data Bank (NPDB)

The National Practitioner Data Bank (NPDB) database was created by the U. S. Congress and contains information regarding medical malpractice payments, clinical privilege actions, civil judgments, criminal actions, and other adverse actions related to health care LPs, entities, providers, and suppliers. It is a crucial resource for verifying the credentials and disciplinary history of health care providers.

Standard Work Element – NPDB

The IHS policy requires the provider to be queried through the NPDB at the time of pre-application or initial application. Once the LP medical staff appointment and/or privileges are approved, the LP is enrolled in a NPDB Continuous Query (CQ).

Initial Appointment/Reappointment: Once an LP is appointed to the medical staff or is approved for clinical privileges, they are enrolled in the NPDB CQ. The NPDB CQ is more effective than a one-time query because it provides ongoing monitoring of health care practitioners and notifies participating organizations within 24 hours of receiving a report concerning an LP. The NPDB CQ enrollment notifies the organization that enrolled the provider by email of any new or updated reports.

At least two employees at each service unit should be designated as NPDB administrators to ensure receipt of reports. The NPDB Reporting Requirements, OIG/LEIE, Medicaid/Medicare, and other Federal programs report exclusions monthly.

Resignation/Termination: When an LP resigns or terminates his/her medical staff membership and/or privileges, the LP's

Continuous Query enrollment is canceled, as required under Federal Regulations.

Receiving Reports: The following outlines the steps to take when the NPDB sends a new or updated report with findings or comments:

1. The NPDB will email the facility's databank administrators when an LP is enrolled in NPDB CQ and a new or updated report is filed on the LP account.
2. The NPDB Databank Administrator will access the NPDB website, obtain the new or updated information report, and notify the CD of the NPDB report. The report may be sent through Secure Data Transfer, but not through regular email.
3. The NPDB Databank Administrator should continue to notify the CD as soon as possible of any new or updated reports received.
4. Clinical leadership are responsible for the next steps, which is documented in the MEC minutes.

Filing NPDB Reports: The MSP should become familiar with the NPDB Guidebook and Reporting Requirements to guide clinical leadership when a report may be required. The NPDB Customer Service Center (1-800-767-6732) is available to assist with providing guidance on reporting requirements. Additional guidance is provided for internal reporting notification by the Agency Clinical Credentials Committee (ACCC).

NPDB – Acceptable Verifications

The NPDB query is produced through the Health & Human Services National Practitioner Data Bank. The query should indicate the name of the facility requesting the report. If the area is set up for centralized credentialing, the area should contact the NPDB to ensure it meets all requirements for proper setup.

NPDB - Software

NPDB reports, unless run through the software, are manually uploaded in the Verification Log of the LP's record in the manner below. If the NPDB needs to be tied to an E>Priv display for clinical leadership, it needs to be uploaded to the Files tab of the LPs record.

The NPDB query should not be listed in the Files section as Global or attached to the License/Credential NPDB entry, as these sections are not facility-specific.

The NPDB CQ is an internal control for reporting in the future.

- **Type**: NPDB (National Practitioner Data Bank)
- **Name**: NPDB (National Practitioner Data Bank)
- **Requested**: The Process Date at the top of the NPDB CQ enrollment
- **Received**: Same as the Process Date
- **Method**: Internet
- **Verified by**: The MSP who verified/enrolled the LP in the NPDB CQ
- **Info Received**: Check this box, this indicates you have received a copy of the NPDB
- **Mark As Negative**: Check this box if there are any reports listed

Note: If the MSP is an IHS purchase cardholder, the NPDB CQ enrollment and verification can be completed through the software. A profession in the Field of Licensure dropdown on the Demographic page must be selected because the NPDB utilizes that field in query enrollments. In addition, the MSP must follow all purchase cardholder requirements for using their purchase card within MD-Staff (See Appendix).

(13) Life Support Certificates

Life support certifications are required according to agency and facility policies, clinical privileges, and medical staff bylaws. Unlike optional first-aid courses, Basic Life Support (BLS) Certification is often mandatory for health care professionals, such as nurses, doctors, and emergency medical personnel. It is a standard certification for those working in health care settings, ensuring proficiency in life-saving techniques.

Standard Work Element - Life Support Certificates
It is IHS policy that Basic Life Support (BLS) certification is required for all LPs who work onsite at IHS facilities. Additional

life support certificates may be required through privilege criteria or area/facility bylaws and policies.

Life support certifications are not required for telemedicine providers or any other provider who does not work onsite.

Acceptable Verifications - Life Support Certificates
The MSP should obtain copies of all certificates (such as BLS, ACLS, PALS, etc.), verify they are current, and ensure the certificate type matches the agency/facility policy requirements and clinical privilege criteria for which the LP is applying.

Software – Life Support Certificates
Each life support certificate type shall be entered only once in the License/Credential section with a copy of the certificate in the provider's Files tab as File Type: Life Support Certifications and Description: Type of Life Support Certificate, e.g., BLS, ACLS, ATLS, etc. When a new certificate is issued, do not enter a new life support certificate type in the Licenses/Credentials. Update the current entry with the new issue and expiration dates, upload the new certificate to the Files section, and then attach the file to the Life Support Certificate in the License/Credentials section. This provides an ongoing record of the life support certificates held.

(14) Immunizations

Immunization records in IHS are maintained by the employee health officer and/or infection control staff at IHS facilities. The IHS Medical Staff Initial Application collects documentation of immunity for Rubella, Measles, Hepatitis B, and Tuberculosis. Pending documentation of immunization records should not hold up the credentialing file approval process.

Standard Work Element – Immunizations
At initial appointment, the MSP shall ensure that the LP completes the Health Screen/Immunization section of the application and provide documentation of MMR (measles, mumps, rubella), PPD, and Hep B. If the applicant declines the Hep B vaccination, they must select "Declined Hep B

Vaccination" under the Result section of the application.

At reappointments, immunizations are not collected.

Immunizations are not required for telemedicine providers or any other provider who does not work onsite.

Acceptable Verifications - Immunizations
Copies of the immunization record.

Software – Immunizations
Immunizations provided on the application are uploaded to the Medical History tab in MD-Staff. The employee health nurse and/or infection control staff should be provided with documentation of immunization records received. This can be accomplished through an E>Priv Display.

(15) Current Liability Insurance

Credentialing files should include documentation of current professional medical malpractice liability insurance coverage or information that the LP is an IHS-employed LP covered under the Federal Tort Claims Act (FTCA). Medical professional liability insurance for contractors is a condition for approval of requested privileges. Employing contractors who do not have current, adequate coverage may put the agency at risk.

Standard Work Element – Current Liability Insurance

Contractors - At minimum, MSPs should verify the LP's current liability insurance at initial appointment and at expiration. The certificate of insurance (COI) should include the LPs name, minimum coverage of $1 million individual and $3 million aggregate coverage, and dates that are current and match affiliation/employment dates. At the time of COI expiration, a new COI shall be obtained from the malpractice carrier or contracting agency.

Employed (IHS) - The Federal Tort Claims Act (FTCA) removes the requirement that IHS employees and Tribal providers carry private malpractice insurance. To understand the type of

protection, coverage, and other related information, visit the IHS Risk Management webpage.

Acceptable Verifications – Current Liability Insurance

- **Contractors** – A copy of the COI from the malpractice carrier or contracting agency.
- **Employed (IHS)** – No verification of FTCA coverage is required.

Software – Current Liability Insurance

Current liability insurance information provided by the applicant, when imported, will display in the Insurance tab in MD-Staff.

- **Source**: The insurance carrier's name
- **Issued Date**: The date the insurance was issued
- **Expires**: Date the insurance expires or expired
- **Retro Date**: Retroactive date of the insurance
- **Policy Number**: Insurance policy number
- **Coverage**: Amount of coverage given by the insurance (e.g., $1M/$3M)
- **Terms**: Any special terms that apply
- **Document**: Merge document associated with the insurance
- **Primary**: Whether or not the insurance is the provider's primary insurance.
- **In Use**: Whether or not the insurance is currently in use

The COI and/or the letter from the Insurance Company received from the Insurance Carrier can be added to the Latest Verification, Verification Log, or Files.

(16) Professional Liability Claims, Suits, and/or Judgements, and Current Liability Insurance

Information gathered on professional liability claims, suits, and/or judgments helps assess an LP's history of malpractice claims and identify patterns of professional liability claims to gauge their professional reliability and risk profile. These verifications help ensure that practitioners meet the high standards expected in health care settings, protecting patients and the integrity of the IHS facility.

Note: In some physician specialties, such as orthopedics and neurosurgery, there is a higher rate of malpractice suits filed. In addition, liability insurance providers may settle some lawsuits because it's less expensive than going through litigation. Often, the provider has no control over these settlements.

Standard Work Element - Professional Liability Claims, Suits, and/or Judgements

The initial application requests the past five years of insurance carriers, including coverage dates and coverage types, as well as a list of open, pending, settled, closed, and dismissed cases. Insurance verifications can be difficult to obtain from insurance companies and verification of **past** insurance coverage should not hold up a credentialing file for review.

Acceptable Verifications - Professional Liability Claims, Suits, and/or Judgements

The IHS utilizes the NPDB to verify an applicant's medical malpractice history and ascertain the background, status, and nature of any malpractice cases associated with the applicant. The open/pending malpractice cases are disclosed through the professional practice questions on the LP's application, affiliation verifications, and peer references.

Software - **Professional Liability Claims, Suits, and/or Judgements**

When imported, professional liability claims, suits, and/or judgments provided by the applicant are displayed in the **Additional Items > Incidents/Claims**.

All findings are documented in the LP's credential file and forwarded to the credentials committee or the CD for review.

(17) Sanctions Disclosure or Current Investigations

Sanctions disclosure and government database checks are integral to the credentialing process at IHS facilities to ensure that LPs meet all regulatory and ethical standards. Excluded providers have had some adverse action taken, such as revocation, probation, civil complaint, etc. Reported on a sanctions list may be considered an adverse credentialing finding.

The Credentialing Committee, CD, and CMO must immediately review any sanctions or exclusions identified.

These checks are performed across various databases:

a) NPDB (see Section 11 above)
b) Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)
c) System for Award Management (SAM)
d) Optionally, for state licenses, the Federation of State Medical Boards (FSMB)
e) State-specific Opt-Out databases

The standard work elements, acceptable verifications, and software for these sanction disclosures or current investigations are provided below.

Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)

The OIG/LEIE maintains and provides monthly updates for practitioners currently barred from participating in CMS and/or other federal health care programs to the NPDB and the OIG/LEIE website due to fraud or misconduct. Checking the OIG LEIE ensures that health care facilities do not employ individuals who might compromise patient safety and compliance with federal regulations.

Standard Work Element - OIG/LEIE

OIG/LEIE is verified for each provider at initial and reappointment. Enrollment in the NPDB CQ meets this requirement for reappointment, as well as any other instances identified by the facility's accrediting/certifying body or Area/Facility policy.

Acceptable Verifications – OIG/LEIE

The results in the MD–Staff—Comments section on the Verification Log OIG will report "No Match." NPDB is also another acceptable primary source verification for OIG/LEIE.

Software – OIG/LEIE

The following fields in MD-Staff are required to be filled in order to run OIG/LEIE database searches:

- First Name
- Last Name
- Social Security Number
- Birth Date
- Any aliases the provider may have

**OIG database is downloaded Every Monday at 7:30 PM PDT by MD-Staff from OIG Exclusions. Please note that OIG only updates this database once a month on average.*

To activate/deactivate which states are included in your Sanction verifications, navigate to **Setup > Web Services > Sanction Settings**

***Note*- IHS recommends that all Sanctions sites are activated.**

Any state with *False* under the *Enable* column is not activated. To activate it, click on it and then click Activate. To run a verification, navigate to Verification > Sanctions and select Verify by Name, Verify by Filter (to verify multiple providers), or Verify All. **Verify All** runs the verification for all providers who are not archived.

The provider's Verification Log contains all OIG verifications. The MSP should review the log to determine whether there was a Match, any Negative findings, or a Review suggested. Additional information can be found by clicking on **Details** in the report. Any findings are forwarded to the credentials committee or the CD for review.

System for Award Management (SAM)

Formerly GSA/EPLS (General Services Administration/Excluded Parties List System) monitors federal agency debarments, including those from the OIG, and other state-required sanction queries. SAM is a federal database that consolidates information on entities, including health care providers, that are prohibited from receiving federal contracts or grants. Checking SAM ensures that LPs are in good standing and eligible to participate in federal health care programs, safeguarding the integrity and compliance of IHS facilities.

Standard Work Element - SAM
At initial and reappointment, each provider is verified for SAM, as well as at any other times identified by the facility's accrediting/certifying body or Area/Facility policy.

Acceptable Verifications – SAM
The results in the MD–Staff—Comments section on the Verification Log for EPLS (SAM/GSA) will say "No Match."

Software - SAM

Note: As a self-hosted site on a version higher than 8.4, our MD-Staff searches by NPI instead of social security number (SSN). However, the comments in the verification log will still say "SSN".

To run a verification, navigate to **Verification > EPLS (SAM/GSA),** then select **Verify by Name, Verify by Appointment Date**; or **Verify All** runs the verification for all providers who are not archived. The following fields are used to run a SAM database search:

- First Name
- Last Name
- SSN
- Any aliases the provider may have (both first and last name aliases)

The provider's Verification Log contains all verifications. Any findings are forwarded to the credentials committee or the CD for review.

Federation of State Medical Boards (FSMB)

The FSMB is a comprehensive primary source data repository for all state licenses, disciplinary sanctions, closed residency programs, and medical staff affiliation. The FSMB can be used as a designated equivalent source that lists all LP active and inactive state licenses and provides reports for closed residency programs. FSMB is a paid verification that is encouraged but not required. The facility may choose to instead primary source verify each state medical board individually.

Standard Work Element, Acceptable Verifications, and Software - FSMB
See Item (6) Licensure above.

Standard Work Element - Centers for Medicare & Medicaid Services (CMS) and State-Specific Opt-Out
The NPDB's Continuous Query issues alerts for new and monthly reports of all CMS sanctions, other federal sanctions, state sanctions, and restrictions on licensure, certification, or scope of practice. Medicare Opt-Out verifies if a provider has opted out of receiving Medicare reimbursement for health care services provided to patients. MD-Staff directly queries the CMS Medicare Opt-out list, maintained and updated monthly by the CMS.

Standard Work Element – CMS State-Specific Opt-Out
At the initial and reappointment, CMS Medicare opt-out verification for each provider is performed.

Acceptable Verifications – CMS State-Specific Opt-Out
The NPDB and the Medicare opt-out verifications can be completed electronically in MD-Staff. Enrollment in the NPDB CQ meets this requirement for reappointment, as well as any other times identified by the facility's accrediting/certifying body or area/facility policy.

Software – CMS State-Specific Opt-Out
To verify Medicare Opt-Out navigate to **Verification > Medicare Optout** and **Verify by Name, Verify by Filter** (select multiple providers), **or Verify All.** Appropriate results in MD-Staff – Comments section on the Verification Log for Medicare Opt-out will say **No Results Found.**

To review the verification results, you can go to the Provider record and select the **Verification Log**. If you run the verification in a batch, go to the **Verifications** menu, and select **Group Verification Log**. Select the **Medicare opt-out verification.** Click **Next to review the results and** determine the practitioner's continued eligibility for credentialing. Furthermore, LPs contesting any inaccuracies found during these checks, ensuring

are typically found in the area/facility medical staff bylaws.

(18) Other Credentials and Verifications

The IHM 3-1 requires that every person seeking membership and/or clinical privileges provide information regarding:

a) denials, restrictions and resignations regarding previous or pending medical staff applications and/or clinical privileges;

b) reduction, suspension, revocation, voluntary or involuntary relinquishment, or non-renewal of clinical privileges;

c) current illegal use of drugs;

d) loss, suspension, restriction, denial of professional licensure or professional society membership, and;

e) convictions.

These are addressed by the professional practice application questions, affiliation verifications, peer references, and through the Personnel Security Representative (PSR), Human Resources, and the acquisition contracting process of hiring.

Additionally, the MSP is aware of and will verify the following items:

Ability to Perform (Health Status)

The health status of LPs is assessed through self-attestation as part of the credentialing application. As an important reminder, these questions and the credentialing application are completed by the LP after offering employment or awarding a contract. LPs must answer questions on the credentialing application form regarding their current health status and ability to practice their profession with reasonable skill and safety. All requests for reasonable accommodation are the responsibility of the human resources department.

Internet Check

Performing an internet search on an LP can uncover additional information not found in traditional credentialing sources, such as news articles, social media profiles, and public records, which may reveal relevant professional or personal conduct issues. This step helps ensure a comprehensive evaluation of the provider and supports informed credentialing decisions.

Standard Work Element – Internet Check

At pre-application and initial appointment, use multiple search engines (e.g., Google, Bing) and list the LP's full name and credentials, professional details (e.g., discipline), or location. Repeat the search with known aliases.

Acceptable Verifications – Internet Check

While not considered a verification and may not be a reliable source, internet checks should provide additional information for the MSP to analyze and corroborate the applicant's information. Look for any red flags, such as reports of malpractice, criminal activity, professional misconduct, or other relevant issues. Consider the credibility and reliability of the information.

Software – Internet Check

Compile a summary of findings, noting the sources and dates of information. Include screenshots or printouts of relevant web pages. File the summary and supporting documents in the provider's credentialing file as File Type – Flagged Items.

Notify the credentialing committee or clinical director if any concerning information is found.

Section 7: Credentialing Adverse Findings and Risk Management

The MSP will review the LP's medical staff applications, forms, and tools to identify any high-risk findings. If any high-risk findings are present, the CD is alerted, and the file must be presented to the Agency Clinical Credentials Committee (ACCC) for an endorsement determination, then considered by the Governing Body.

A request for endorsement from the ACCC may only be submitted if the MEC and GB concur that an endorsement is warranted. The IHS Headquarters ACCC will review the requested endorsement determination. Endorsements must be received before final GB approval and before the licensed practitioner can provide patient care.

The GB or a delegated GB committee retains the final authority to grant, renew, or deny privileges, after considering the recommendations of the medical staff. CMS 42 CFR 482.12/ Joint Commission MS.06.01.07 EP8.

ACCC initial reviews are not considered professional review actions and are not reportable to the National Practitioner Data Bank, as the applicant does not meet our threshold criteria.

High-risk credential findings can cover any aspect of an LP's application, including but not limited to, education, training, licensing, experience, professionalism, and conduct.

High-Risk Credentialing Findings include:

A high-risk credentialing finding is identified as an applicant answering yes to any of the identified professional practice questions in "Table 1. Credentialing High-Risk Table" on an application.

In addition, if any of the documents or verifications supporting the application illustrates that the applicant should have answered yes to a professional practice question but did not, the applicant is contacted to confirm the response.

Please note: The numbers associated with the Professional Practice Questions correspond with the questions on the applications.

Table 1. Credentialing High Risk Table

Credentialing High-Risk Findings	Professional Practice Questions on Applications
Suspension, restriction, revocation, denial, probation, or involuntary relinquishment of any clinical professional license or registration held by the licensed practitioner	1. Has your license to practice in any jurisdiction ever been or ever attempted to have been denied, restricted, limited, suspended, revoked, canceled, reprimanded, or censured, and/or have you ever practiced without a license? 2. Has your license to practice ever been subject to probation, either voluntarily or involuntarily? 4. Has any disciplinary actions or investigations ever been initiated against you by any state licensure board? 5. Have you ever been reprimanded and/or fined, by any local, state, or federal agency that licenses providers? 6. Have you ever been subject to informal or formal proceedings (including hearing processes) by the federal government or any branch of the military, licensing board, hospital, health care organization, agency or professional association to revoke, suspend, restrict or limit a professional license/registration/ permit? 7. Have you ever been the subject of a complaint, or have you ever been notified in writing that you have been investigated as the possible subject of a criminal or civil action by any state or federal agency that licenses providers?

Credentialing High-Risk Findings	Professional Practice Questions on Applications
Suspension, restriction, revocation, or denial of employment, medical staff membership, or clinical privileges at any place of employment, including hospitals, clinics, or other health care settings	9. Have you ever been cautioned, reprimanded, or disciplined by any institution, any local, state, or national professional society, regulatory agency, or place of employment? 10. Has your employment and or clinical privileges at any hospital, clinic, or other health care setting ever been denied, suspended, revoked, reduced, restricted, not renewed, voluntarily or involuntarily relinquished, denied renewal, or has probation ever been invoked?
Subject of a civil, criminal, or administrative action regarding sexual misconduct, child abuse, domestic violence, or elder abuse;	8. Have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action by any health care organization (e.g., hospital, HMO, PPA, IPA), professional group or society, licensing board, certification board, PSRO or PRO? 22. Have you ever been the subject of a civil or criminal complaint or administrative action, or are you being investigated as the possible subject of a civil, criminal, or administrative action regarding sexual misconduct, child abuse, domestic violence, elder abuse, or any other violent crimes?

Credentialing High-Risk Findings	Professional Practice Questions on Applications
Participation in the diversion of controlled substances at any health care facility, including a pharmacy	15. Has your federal DEA number, state controlled substance license, or other controlled substance license ever been suspended, revoked, restricted, limited, or relinquished either voluntarily or involuntarily? 16. Have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to a DEA or other controlled substance registration or license?
Documented affiliation or verification of a less than favorable separation or disciplinary action imposed by any employment, hospital, or health care facility related to patient care or provider misconduct	10. Has your employment and or clinical privileges at any hospital, clinic, or other health care setting ever been denied, suspended, revoked, reduced, restricted, not renewed, voluntarily or involuntarily relinquished, denied renewal, or has probation ever been invoked?
Any arrest, charge, conviction, or sentence for the following crimes: Driving under the influence (DUI) or while impaired or intoxicated	25. Do you have any reason to believe that you could pose a risk to the safety or well-being of patients? 27. Have you ever been arrested, cited, charged with or convicted of a felony or misdemeanor other than minor traffic violations, regardless of the outcome? This includes withheld judgements and matters that have been expunged.

Credentialing High-Risk Findings	Professional Practice Questions on Applications
Any sexual misconduct	22. Have you ever been the subject of a civil or criminal complaint or administrative action, or are you being investigated as the possible subject of a civil, criminal, or administrative action regarding sexual misconduct, child abuse, domestic violence, elder abuse, or any other violent crimes? 27. Have you ever been arrested, cited, charged with, or convicted of a felony or misdemeanor other than minor traffic violations, regardless of the outcome? This includes withheld judgments and matters that have been expunged.
Illicit illegal drugs forbidden by federal law	23. Are you aware of any impairment, including but not limited to a medical impairment, that you or an objective third party might think would limit your ability to meet the duties associated with clinical staff membership? (If a reasonable accommodation would allow you to exercise your clinical privileges and clinical staff duties completely and safely, please refer to the Indian Health Manual, Part 1, Chapter 14, for additional information on requesting accommodation.) 24. Are you currently engaged in illegal use of any legal or illegal substances? 27. Have you ever been arrested, cited, charged with, or convicted of a felony or misdemeanor other than minor traffic violations, regardless of the outcome? This includes withheld judgments and matters that have been expunged.

Credentialing High-Risk Findings	Professional Practice Questions on Applications
Intimate partner violence or other violent crimes	22. Have you ever been the subject of a civil or criminal complaint or administrative action, or are you being investigated as the possible subject of a civil, criminal, or administrative action regarding sexual misconduct, child abuse, domestic violence, elder abuse, or any other violent crimes? 27. Have you ever been arrested, cited, charged with or convicted of a felony or misdemeanor other than minor traffic violations, regardless of the outcome? This includes withheld judgements and matters that have been expunged.
Not Board Certified or Board Eligible or historically exempt from the Board Certification/Eligible Requirement	None

In addition to the table above, it is suggested that the Area CMO review and consider any positive responses to the remaining twelve (12) professional practice questions (listed below, identified by numbers associated with the application) if the file needs an ACCC review.

> 3. Has your license ever been voluntarily or involuntarily withdrawn?
>
> 11. Have you ever voluntarily or involuntarily withdrawn your application for clinical privileges or terminated clinical privileges prior to a hospital or health facility's governing board's final decision?
>
> 12. Have you ever been reprimanded, censured, excluded, suspended, disqualified and/or participation voluntarily withdrawn, to avoid an investigation by Medicare, Medicaid,

TRICARE, and/or any other governmental health related programs?

13. Have Medicare, Medicaid, TRICARE, PRO authorities, and/or any other third-party payers ever brought charges against you for alleged inappropriate fees, and/or quality of care issues?

14. Has any information pertaining to you, including malpractice judgements and/or disciplinary action, ever been reported to the National Practitioner Data Bank or any other practitioner data bank, or any other federal or state board oversight authority?

17. Have you ever had a claim for professional negligence asserted against you? If yes, you are required to note your final judgement and settlements in the Malpractice Claims section of this application.

18. Have liability claims, judgements or settlements ever been made against a hospital, corporation, or the United States Government in professional liability suits based on a case with which you were professionally associated? If yes, you are required to note the final judgement and settlements involving yourself as a practitioner in the Malpractice Section of this application.

19. Have you ever had professional liability coverage denied, refused, or canceled by a professional liability insurance company?

20. Have you ever withdrawn from or been suspended, dismissed or expelled from a professional school or postgraduate training program, or has any third party ever attempted to have you withdrawn, suspended, dismissed, or expelled from a professional school or postgraduate training program?

21. Have you ever been placed on probation or taken a leave of absence from medical, dental, or other graduate school or postgraduate training program?

26. Has it been more than 12 months since you have provided patient care in a professional setting?

28. Were you ever the subject of any disciplinary action at any educational (college) or training (residency, fellowship, internship, etc.) programs?

The ACCC will provide additional guidance such as submission forms, timeline, process, etc. and is outlined in the ACCC policies and procedures. For additional guidance please refer to IHM 3-1.3 F.

Risk Management

Clinical risk management that supports quality and safe patient care is an IHS priority. Clinical administrators and other licensed practitioners should review and familiarize themselves with the IHS Risk Management Manual. This manual discusses risk management as it relates to medical care and medical malpractice tort claims within the federal system. Risk management techniques will improve the quality of patient care and proactively reduce the probability of an adverse outcome turning into a medical malpractice claim. It is also important to analyze and learn from the tort claims that have occurred in relation to system issues that require intervention. The overall goal in health care risk management in both situations is to minimize the risk of:

- harm to our patients
- liability exposure of our health care providers
- financial loss to the agency

Section 8: Shared Documents

Sharing of Credentialing and Privileging Documents and Verifications

All requests for credentialing records, including Freedom of Information and medical quality assurance requests, must be approved through the Service Unit Privacy Act Liaisons and/or the Area Office Privacy Coordinator. Credentialing records are protected by U.S. Code 25 §1675. The Privacy Act can be found here: https://www.govinfo.gov/content/pkg/CFR-2015-title45-vol1/xml/CFR-2015-title45-vol1-part5b.xml

Indian Health Service Medical Staff Credentials and Privileges Records System of Records Notice (SORN) can be found here: https://www.govinfo.gov/content/pkg/FR-2023-05-23/pdf/2023-10835.pdf. It lists the authority for the collection of information, the categories of individuals whose records are collected, the categories of records in the system that do not require a signed release of information.

IHS, as one agency using one credentialing software, may share some credentialing and privileging records as part of routine use.

The IHS Credentialing System of Records Notice 09-17-0003, 4. states:

"Records may be disclosed to other Federal agencies or organizations, to state and local governmental agencies, and to organizations in the private sector to which the subject individual applies for clinical privileges, membership, or licensure to enable them to document the qualifications, character, and competency of the individual to provide health services in his/her health profession based on his/her professional performance while employed by the IHS."

Contact the Service Unit Privacy Act Liaison and/or the Area Office Privacy Coordinator for any questions relating to any Privacy Act questions or issues.

What credentialing records can be shared and used between IHS facilities?

Primary source verifications of static credentials, meaning verifications that will not change if reverified, such as completed medical staff education, internship, residencies, malpractice history verifications, and past affiliations, may be shared within IHS for credentialing providers who are seeking appointment at another IHS facility, if:

1) the prime source verification organization* permits sharing; and
2) if the receiving facility has the consent of the applicant by means of a current application and a current signed IHS Conditions of Application and Release (releases are valid for one year); or
3) the IHS area is formally set up as a centralized verification organization;

**Most verifying organizations that require payment for the verification do not permit sharing. If unsure, you can call the organization to inquire or read their terms of use.*

Verifications of state medical licensure, DEA registration, CDS licensure, SAM, NPDB, CMS, OIG queries, and current malpractice verifications may **NOT** be shared unless the IHS Area is established as a centralized credentialing office. Most of these verifications are required by accrediting organizations to be verified **AT** the time of appointment. Additionally, peer references can be shared and are considered current if the reference's signature is within two years of the file presentation to the GB.

By software design, only facilities associated with the provider can see and use records labeled as Global. If records need to be shared via email, you must use the secure data transfer system, as most records include personally identifiable information.

Information about sharing licensed practitioners their records:

MSPs can only share records and documents submitted by the LP. LPs may not have access to any verifications, queries, or any documents completed, processed, verified, or received for credentialing purposes. As an example, if the LP submits a copy of their CV, diploma, or license, we can provide those to the LP. However, we cannot provide them with a copy of the affiliation verifications, peer references, education verification, etc.

The at-a-glance table below lists documents and verifications are shareable and not shareable within IHS facilities, along with where/how the records are filed in the software and whether the record can be shared with the practitioner.

The facility credentialing and privileging the provider may choose not to use the records and/or verifications completed by other facilities and may choose to perform their own. However, these documents and verifications must be designated as Global in the Files section of the provider's record for facilities that wish to use them. Either method may be used, but a complete credentialing file and supporting verifications is required.

Documentation Verification	Shareable within IHS?	Files Section	Shareable to LP	Additional Information
IHS Conditions of Application and Release	No	Facility Specific	Yes	
Initial Application	No	Facility Specific	Yes	Each facility should obtain its own initial application and privileges. The system will have most fields completed for the LP, so this is not an additional burden.
Proof of Identity	No	Facility Specific	No	Each facility should conduct its own identity verification at the initial appointment.
Medical Diploma, Internship, Residency and Fellowship Certificates	Yes	Global	Yes	
Medical Degree Verifications	Maybe	Global - If provided by the Program If purchased – Facility Specific	No	Verifications directly from the school may be shared. The following organizations do not permit sharing of their profiles or verifications: AMA, AOA, and NSC
ECFMG Certificate	Yes	Global	Yes	
ECFMG Validation Verification	No	Facility Specific	No	The organization does not permit sharing.
Internship, Residency, and Fellowship Verification	Maybe	Global - If provided by Program If purchased – Facility Specific	No	Verifications directly from the internship, residency or fellowship programs may be shared. The following organizations do not permit sharing of their profiles or verifications: AMA and AOA.
Written Time Gap Responses	Yes	Global	Yes	

Documentation Verification	Shareable within IHS?	Files Section	Shareable to LP	Additional Information
Court Records	Yes	Global	Yes	If provided by applicant, can provide back.
State Licenses Certificates	Yes	Global	Yes	
State License Verifications	No	Facility Specific	No	All state licenses (active and inactive) are verified at the time of initial appointment. All active licenses are verified on an ongoing basis, e.g., reappointment, at license expiration, and any time there are changes in privileges or any new privileges requested at each facility.
Drug Enforcement Administration (DEA) Registration and State Department of Public Safety (DPS), and Controlled Dangerous Substance (CDS) Certificates	Yes	Global	Yes	
DEA, DPS, and CDS Verifications	No	Facility Specific	No	All registrations for the DEA, DPS, and CDS are verified at initial appointment, expiration, and reappointment by each facility.
Board Certification Certificate	Yes	Facility Specific	Yes	
Board Certification Verification	No	Facility Specific	No	All Board Certification are verified at the initial appointment and at the time of expiration. At reappointment, only if required by the accrediting body.

Documentation Verification	Shareable within IHS?	Files Section	Shareable to LP	Additional Information
Practice History- Affiliations, Work History, and Military verifications	Maybe	Global if the affiliation, work history, or military time has ended and no new information would be gained from reverifying. Facility Specific if current/open	No	If the time the LP practiced has passed when the verification was processed and there is no additional time to verify, these verifications may be shared, as no new information would be gained. If the time the LP practice is still opened at time of appointment, another verification must be obtained.
Life Support Certificates	Yes	Global	Yes	
Immunization Records	Yes	Global	Yes	
Continuing Medical Education Certificates and Summaries	Yes	Global	Yes	
Peer Reference	Maybe	Global if current	No	If the peer reference is within two years of presenting file to GB it can be used, otherwise obtain new peer references.
Certificate of Insurance (COI) (Current malpractice insurance)	Maybe	Global	Yes	For IHS hires, no COI documentation is required, they are covered by FTCA. For contractors, malpractice COI may be shared. The receiving facility must ensure that the COI covers the individual requesting privileges, is current, is consistent with clinical privileges being requested, coverage does not include any exclusions and meets professional liability coverage

				with limits that meet or exceed IHS requirements of $1 million individual and $3 million aggregate. At the time of expiration, a new certificate of insurance shall be obtained.
Documentation Verification	**Shareable within IHS?**	**Files Section**	**Shareable to LP**	**Additional Information**
Malpractice History Verifications	Maybe	Global	No	Yes, if the malpractice history time has passed and no new information would be gained by verifying, those verifications may be shared. If the malpractice coverage time is open, the malpractice history verifications are verified by the facility.
National Practitioner Data Bank Query	No	Facility Specific	No	Each facility is required to verify and enroll each LP. If the facility meets the NPDB requirements to share and the facility is set up with the NPDB to share, then queries can be shared between those facilities.
Office of Inspector General (OIG) Exclusions Database	No	Facility Specific	No	Each facility is required to verify the OIG Exclusion database for each LP
GSA Exclusion	No	Facility Specific	No	Each facility is required to verify the GSA for each LP
Medicare Opt Out	No	Facility Specific	No	Each facility is required to verify the Medicare Opt Out list for each LP
National Provider Identifier (NPI)	No	Facility Specific	No	Each facility is required to verify each LPs NPI.
Documentation Verification	**Shareable within IHS?**	**Files Section**	**Shareable to LP**	**Additional Information**

Exit Clinical Performance Summary IHM 3-1.3 (E).	Yes	Global	No	ECPS is saved in the Files section and listed as Global for sharing purposes within IHS only.
Procedure Logs	Yes	Global	No	

Below is a table that illustrates what tabs/sections in MD-Staff are global, facility specific, and/or shared.

- Facility Specific - only the facility can view the information in that section for their providers.
- Shared (Global) - all facilities that are affiliated with that provider can view.

Credentialing	**Facility Specific**	**Shared (Global)**
Summary	Display Only No Data Entry	Display Only No Data Entry
Demographic		X
Cycles	X	
Appointment	X	
Address		X
Hospitals		X
Education/Training		X
Other References		X
Peer References		X
Licenses/Credentials		X
Board Certifications		X
Specialties	X	
Insurance		X
Medical History		X
Files	X (unless marked global)	X (if marked global)
Verification Log	X	
Checklists	X	
Associates	Facility Specific	Shared
Supervisors	X	
Coverage	X	
Referrals	X	
Additional Items	Facility Specific	Shared
Dues	X	
Other Events	X	
Incidents/Claims	X	
Aliases		X
Employment	X	
Leadership	X	

Passports/Visas		X
Medical Societies		X
Notes	X	
Verification Enrollment	X	
Jump To	Facility Specific	Shared
View Privileges	X	
Record Privileges	X	
Proctor	X	
Enrollment	X	
Mail Log	X	

Section 9: Privileging Process

Privileges refer to the specific procedures and patient care services that an LP may perform or administer at a facility. Expertise within certain areas and the ability to perform procedures are determined by the facility and described in privilege forms. For example, physicians are required to complete medical school, but not every physician has the expertise or experience to perform orthopedic surgery. A facility must review the LP's credentials and grant specific privileges to allow the LP to practice. An organization's process to determine whether to grant or deny permission for a practitioner to engage in these clinical practices is called *privileging*.

Privileges authorize LPs to provide specific clinical services directly to patients or in support of patient care. Administrative duties do not require clinical privileges. Privileges are both practitioner and facility-specific, meaning that clinical privileges are based on a review of individual LP credentials and competency along with the facility's capabilities to support providing those services.

Medicare *Conditions of Participation* (*CoP*) for hospitals require the GB to ensure that the medical staff, through its medical staff bylaws, has criteria for evaluating and determining clinical privileges. Criteria should include individual character, competence, training, experience, and judgment according to their licensure.

Current Competency – The MEC and GB ensure that only qualified, competent LPs perform procedures and provide patient care. Each applicant's competency and performance is continuously evaluated through professional practice evaluations to maintain clinical privileges. LPs who wish to provide health care services to patients must apply and be granted clinical privileges by the GB. Some privileges may require the completion of certain certifications or training, such as Nexplanon procedures.

Low/No Volume Practitioners – Guidance is forthcoming.

Privilege Criteria

Threshold eligibility criteria are in place and consistently applied to each new applicant for medical staff membership and privileges. It is important to identify what criteria apply to membership and what criteria apply to specific clinical privileges.

Do not accept applications for membership or clinical privileges from applicants who do not meet your criteria. However, if you accept and begin processing an application from a practitioner found not to meet your requirements, you may discontinue the application process after discussing with the CD. The LP would then be informed that he or she does not meet eligibility requirements, and the application process has been discontinued.

Establishing threshold eligibility criteria will prevent a fair hearing process with the applicant and from having to file a report with the NPDB. These actions are not required when a LP does not meet eligibility requirements. Only in cases where an application is denied because of concerns related to competence or conduct is when an NPDB report must be submitted.

At a minimum, privilege criteria should address required education level, formal training requirements, and current experience.

Collaborative Practice Agreements for Pharmacists

Collaborative practice agreements (CPAs) define the scope of practice for pharmacists by outlining specific clinical services they are authorized to provide. The terms of the CPA inform the delineation of privileges for these LPs. For LPs requiring a CPA, delineation of privileges should match the privileges listed in the agreement, to ensure compliance with regulatory standards.

Refer to the Indian Health Manual 3-7 (Pharmacy) for detailed procedures on creating and executing a CPA. The CPA is developed in collaboration with the supervising LP.

Once all relevant parties have finalized and signed a CPA, the MSP saves a copy of the agreement in the LPs credential file. The applicant must return the signed CPA to the MSP to complete the credentialing file.

Temporary Privileges

Facilities whose accrediting body does not provide temporary privileges standards should abide by the following procedures and processes when temporary privileges are required. Temporary privileges should only be used in rare and extraordinary circumstances and only for LPs with a complete, clean file (defined below). The CEO upon

recommendation from the MEC Chair may grant temporary privileges not to exceed 30 days at one time and not to exceed 120 days in totality.

Temporary privileges must include notification to the area CMO and meet one of the following service hardships: 1) an important patient care service or treatment need exists; and 2) when an applicant for new privileges* is awaiting review **and** approval by the MEC and the GB.

Temporary privileges cannot be granted due to administrative issues, such as when an applicant fails to provide all information necessary to process their reappointment on time or when the file's verification, review, and approval are not conducted on time. Documentation of the service hardship and notification to the Area CMO must be filed in the provider's file in the current credentialing software as File Type: Memo/Correspondence.

**Note: Applicants for new privileges include an individual applying for clinical privileges for the first time, an individual currently holding clinical privileges who is requesting one or more additional privileges, and an individual who is in the reappointment/re-privileging process and is requesting one or more additional privileges.*

According to IHS, what is defined as a complete, clean file for expedited review and approval?

Complete, clean credentialing files can be reviewed and approved according to the facility's accrediting body requirements and processes for expedited review and approval. IHS defines a complete, clean file as:

1) A complete medical staff application with verified and documented evidence of current competence, character, judgment, education, training, and licensure.
2) No current or previously confirmed challenges or restrictions on **any** state license, certification, or registration.
3) No subjection to involuntary termination of medical staff membership at another organization.
4) No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges.
5) No "yes" responses on the professional practice questions on the IHS Medical Staff Application(s).

6) No “yes” responses to disciplinary actions for medical education, internships, residencies, or fellowships.

7) No “yes” responses on peer references and/or affiliation verifications that correspond with any of the IHS high-risk credentials findings.

8) National Practitioner Data Bank (NPDB) and Office of Inspector General (OIG) queries with no reports or negative findings.

9) Previous IHS Exit Clinical Performance Summary has no negative findings, if applicable.

Only LPs with a complete, clean file (defined in this manual) may be considered for temporary privileges or expedited review and approval. Temporary privileges shall follow the facility’s accrediting body standard requirements, facility medical staff bylaws and policies, the agency policy, and the SOP manual.

Applicants granted temporary clinical privileges are subject to the same credentialing process as other applicants. If the practitioner’s license is not renewed, is revoked, restricted, or there is cessation of appropriate liability insurance coverage (as applicable), temporary privileges shall cease immediately.

Section 10: Emergency and Disaster Privileges

Emergency Privileges

Emergency privileges are granted by the medical staff to existing LPs to allow them to perform a task outside the scope of privileges they have been approved to save a patient's life, limb, or organ. Emergency privileges legitimize the actions of LPs when patients are in extremis.

Disaster Privileges

Disaster privileges are granted to LPs who are not members of the medical staff so that non-employee staff are allowed to provide patient care services in the institution when the disaster plan has been invoked. As soon as a LP with appropriate privileges can assume care, the LP with emergency privileges relinquishes those privileges.

Disaster privileges are only implemented when an institution is experiencing a disaster at the facility or in the community and the facility's Emergency Operations Plan has been activated. The plan allows rapid credentialing of certain LPs based on proper identification and their membership on one of several disaster management teams.

Although these LPs are identified as members of a disaster management team or by personal reference, the medical staff services department must still try to primary source verify each LP's licensure within 72 hours, if possible. The medical staff needs to determine how the LP's performance will be supervised. Within 72 hours, the medical staff needs to decide, based on a practitioner's performance, whether his or her disaster privileges will be continued or not. Note that disaster privileges automatically expire when the disaster concludes.

MSPs should review the medical staff bylaws regarding emergency and disaster privileges to ensure they understand the differences and implement them appropriately.

Standard Work - Disaster Privileges

Privileges Granted in Response to a Disaster. Facilities experiencing disaster conditions, declared public health emergencies or a patient surge in which the facility's emergency operations plan has been activated shall manage volunteer LPs according to the facility's accrediting body standards, medical staff bylaws, and/or local policies.

Facilities whose accrediting bodies do not provide standards for disaster privileges should follow the following procedures and processes when disaster privileges are required.

When the medical staff anticipates they are unable to handle the immediate patient needs due to a disaster, a declared public health emergency or patient surge, the clinical director (or equivalent) or the chief executive officer (CEO) has the authority to grant disaster privileges to LPs upon presentation, verification, and documentation of proof of identity and evidence of current clinical qualifications.

1. Proof of identity: A valid picture identification card issued by a State, Federal, or regulatory agency of the volunteer.
2. Evidence of current clinical qualifications:
    a. c current and valid IHS or non-IHS health care facility-issued photo identification
    b. current license to practice
    c. identification indicating the individual is a member of a disaster medical assistance team
    d. ddentification indicating that the individual has been granted authority to render patient care in disaster circumstances (e.g. authority granted by a federal, state, or municipal entity)
    e. attestation by current facility or medical staff member(s) with personal knowledge of the practitioner's clinical qualifications

Primary source verification of licensure should occur as soon as possible and, at most, within 72 hours from when the volunteer LP presents to the facility. If primary source verification cannot be obtained within 72 hours, the facility will document the reason(s) it could not be performed every 72 hours thereafter until verification is completed.

The regular application and credentials verification process must be completed as soon as possible for all LPs who were granted disaster privileges even if the LP’s privileges with a facility have already ended.

The medical staff must have a process in place to oversee the performance of each volunteer LP. Based on its oversight of each volunteer LP, the facility determines and documents that, within 72 hours of the practitioner's arrival, disaster privileges shall continue if granted.

Emergency Privileges

Emergency privileges are simply temporary privileges granted in an urgent situation. The CEO may grant emergency privileges on the recommendation of the medical staff/chief of staff.

Section 11: Staff Designations and Appointment Page Fields

The medical staff shall be composed of licensed as determined by the local medical staff and its GB, and defined in its policies and procedures manual and medical staff Bylaws. Each medical staff member who provides medical services must meet the medical staff credentialing and privileging standards of a nationally recognized accrediting/certifying body, such as The Joint Commission, the American Association for Ambulatory Health Care (AAAHC), and the Centers for Medicare and Medicaid Services. The medical staff status and category are determined for all LPs.

Medical Staff Statuses

The facility's medical staff bylaws should define medical staff statuses, which define qualifications, citizenship duties, prerogatives, rights, and responsibilities of the medical staff in the identified categories for the facility. This field must be completed to assist HQ in providing reliable reports on LPs. At minimum, the following medical staff statuses are used to identify LPs staff membership in MD-Staff.

There are several different statuses of medical staff membership that can be granted by a facility's GB, and at a minimum the following statuses are defined in the facility's medical staff bylaws and recorded in the software on the Appointment page.

1. **Active** – Active members of the medical staff, such as physicians, dentists, podiatrists, optometrists, and APRNs, and PAs, who are federal employees and/or spend at least 50 percent (or an amount specified in the local medical staff bylaws) of their professional time providing direct patient care services, clinical supervision, or clinical administration in a facility. Active members are generally voting members with exceptions per facility bylaws.
2. **Associate (Consultant/Courtesy)** – A LP who is a temporary, intermittent, or a part-time (less than twenty hours) employee of IHS or a non-IHS employee such as contractors, locum tenens, consultants, or volunteer practitioners. Members of the medical staff who generally provide medical services on an intermittent, periodic, or episodic basis (e.g., specialty clinics, provide clinical consultation) such as contractors, locum tenens, non-federal consultants or volunteer practitioners. This also includes federal employees who work less than 20 hours (or an amount specified in the

local medical staff Bylaws). Generally, these LPs are non-voting members, with exceptions per facility bylaws.

3. **Honorary** – a long-term employee and member of the Medical Staff has been given special compensation to remain a consulting member of the medical staff, without patient care responsibilities or privileges, but may attend medical staff meetings and contribute to discussions for the benefit of the medical staff. They are generally non-voting members with exceptions per facility bylaws.

Other Statuses to select in the software:

1. **Allied Health** – A LP employed by the IHS that does not meet the qualification of permanent staff (Active) or Associate (Consultant/Courtesy.) Examples include pharmacists, physician assistants, clinical psychologists, clinical social workers, audiologists, physical therapists, and occupational therapists. Generally, non-voting members with exceptions per facility bylaws.
2. **Other** – Any non-LP employed by the IHS; examples could include non-licensed residents, students, nurses, technicians, or others that do not fit the other category groups. Non-voting members of the medical staff.

Category

Categories are used in the software to characterize the LP time-based relationship with the medical staff as performance is monitored according to the facility's accrediting body standards and local medical staff Bylaws/policies. This field is required to be completed and assists HQ in providing reliable reports on LPs.

1. **Provisional** - This “provisional/conditional status” in the credentialing software indicates the LPs performance is being monitored after the initial appointment and/or initial privileges are granted according to the facility's accrediting body standards and local medical staff bylaws/policies.
2. **Active (Continuous)** - Indicates the LP has successfully transitioned off the facility’s initial monitoring.
3. **Credentialing by Proxy (CBP)** – Indicates the LP is credentialed by proxy, is listed on a schedule 1 roster, and there is a signed agreement and contract in place. Additional

4. requirements are spelled out in the CBP section of this manual.
5. **Emergency/Disaster** - Indicates the LP is privileged under time-limited circumstances designated as an emergency/disaster following and adherence to the facility's accrediting body standards, medical staff bylaws, and policies. Disaster privileges are only allowed to be granted when the facility's Emergency Operations Plan (EOP) has been activated.
6. **No Privileges** – Indicates the employee does not have clinical privileges. This may be employees who hold a license, which the facility desires to use the software to track for monitoring, accreditation or non-accreditation purposes.
7. **Temporary** - Indicates the medical staff has granted a new LP temporary privileges according to and adherence with the facility's accrediting body standards, medical staff bylaws, and the directives set forth by IHS. Temporary status in the software is replaced with "Provisional" after full privileges have been granted and approved by the Governing Body.

Staff Type (Employment Type)

This field within MD-Staff is used to differentiate employees by the relationship that the LP has with the facility with respect to employment. Generally, most federal employees and Commissioned Corp officers will fall under the permanent staff type. However, some of these permanent staff types may fall under administration. Please see the descriptions below.

1. **Administration –** Administration is designated as the primary role, and direct patient care is the secondary role. This includes very low volume patient care during the year and/or does not see patients). Examples could include CMO, CD, Section Chief, Department Head, and Area Consultant.
2. **Contractor**
   a) These individuals are employees of a separate facility or company (not a Locum Tenens company) that has a contract with the local IHS facility for specific services offered continually for a long-term period.
   b) Has a contract or agreement (MOU/A) with the local facility. Examples could be Tribal Providers working within a Federal facility, Diagnostic Imaging Associates (DIA), etc.
3. **Locum Tenens**

a) These individuals are hired through a Locum Tenens company for intermittent services or to fulfill patient care needs.

4. **Permanent Staff**
   a) These are federal employees hired by the facility in a full-time or part-time capacity who are credentialed and privileged, and primarily provide direct patient care.
5. **Resident**
   a) These individuals are completing their clinical residency through a formal residency program with a Memorandum of Understanding/Agreement (MOU/A) with an IHS Area/facility.
6. **Student**
   a) These individuals are students from an institution with a MOU/A with the IHS Area/facility, allowing for learning from providers and other staff at the facility level.
7. **Nurse (Non-LIP)**
   a) These individuals are current employees and contractors who are not credentialed or privileged and are put into the electronic credentialing system to track items, such as BLS/ACLS, licensure, certification, etc.
   b) Examples could include RN, LPN, and medical technicians.
8. **Technician**
   a) These individuals are current employees and/or contractors who are not credentialed or privileged but are put into the electronic credentialing system for the purpose of tracking items, such as licensure, certifications, etc.
   b) Examples could include radiology, ultrasound, lab, or pharmacy.
9. **Volunteer**
   a) Non-medical or health care field-focused study students, such as Dental, Medical, and Vision students, volunteering outside any structured MOU.
   b) Disaster/Emergency activation, allowing volunteers to provide services through disaster privileging.

Corporate Status (Employer Type)

This field defines the organization/employer to which the employee belongs.

1. Contract Companies (Includes Locum, Tele-Health, Universities, and other contracted service companies.) This drop-down provides a listing of all the companies and/or organizations to which employees are assigned. If a company and/or organization not listed, reach out to the IHS HQ Credentialing Program Manager.

2. Individual Contractor (Personal Services Contractor)
3. IHS - Commissioned Corps
4. IHS - Civil Servant
5. Tribal MOU/MOA Employee

Physical Location (Work Location)

This field defines the location in which the provider is primarily located.

- Choose the location where the provider is stationed most of the time. This may or may not be the service unit listed on the appointment tab in MD-Staff.
- For telemedicine providers who never go on site at the facility, select (Non-IHS Tele Med) Exclusively. If they go on site and/or are an IHS telemedicine provider, select your facility.
- Please note when running reports and/or setting up displays "Physical Location" field will be called "Hospital Based".

Resign Reason

Documents why a provider separates from their appointment to the medical staff. These examples help illustrate the specific circumstances under which each reason might be applied.

- **Provider Assignment Ended:** Provider's contract concluded and was not renewed. The status would be marked as "Provider Assignment Ended." An exit summary is required.
- **Deceased:** If the provider dies while still actively credentialed by the hospital/clinic, their status will be updated to "Deceased." An exit summary is not required.
- **Denied Application:** The completed credentialing and privileging application was presented to the GB, but was not approved. This would be documented as "Denied Application." An exit summary is not required.
- **Incomplete:** The credentialing process was started but not completed and did reach the MEC or GB. As such, the status would be marked as "Incomplete" due to the absence of essential components of the evaluation process. An exit summary is not required.
- **Retired:** The LP retired voluntarily while holding active privileges, and their status would be categorized as "Retired." An exit summary is required.
- **Terminated (with cause):** Provider terminated due to a medical staff or personnel action. This situation is designated as "Terminated (with cause)." An exit summary is required.

- **Transferred (within the organization):** The provider requested a transfer to a different service unit location. Provider status would be updated to "Transferred (within organization)." An exit summary is required.
- **Voluntary Resignation:** The LP resigned independently while still holding active privileges. The appropriate resignation reason noted would be "Voluntary Resignation." An exit summary is required.
- **Withdrawn:** Provider ceased to pursue the credentialing process voluntarily. The designation is "Withdrawn." Exit summary is not required.
- **Unfavorable-PSR:** PSR/HR determined that the applicant is unfavorable for hire with the Indian Health Service. This is not reportable to NPDB as it is not a medical staff action. No exit summary is required unless the provider has been working with a pre-clearance status and the Defense Counterintelligence and Security Agency returns an unfavorable result.

Section 12: Appointment Timeframes and Turnaround Times

Appointment Timeframes

Appointment timeframes indicate how often credentialing and re-credentialing is performed. For IHS, initial appointments are one year long, and reappointments are two years long, regardless of accrediting body medical staff standards or medical staff bylaws.

Appointment dates listed in MD-Staff on the LPs Appointment page will correspond with the dates on the LPs appointment signature page and be documented according to the following Standard Work.

Standard Work - Appointment Page Fields

Pre-Application Sent: Date pre-application was sent to the provider (if using a pre-application, this date must be manually populated).

Pre-Application Received: Date pre-application was received by the MSP (if using a pre-application, this date must be manually populated).

Application Sent: Date application was sent to the provider. Generated by the system.

Application Submitted: Date application was submitted by the provider. Generated by the system.

Application Received: Date application was imported by the MSP. Generated by the system.

Application Type: What type of application is the provider currently completing.

Application Reason: Reason for the application.

Application Status: Status of the application (ex: one year, two year, Schedule One.)

Application Processed: This date is used to calculate workflow reports around application processing times. For example, if Aiva Cycles are being used, this will populate when the checklist is complete. If not using Aiva Cycles, the MSP must complete this date when all items on the checklist are completed and the file is ready for review and approval.

Anticipated Start Date: The date that the provider will begin seeing patients in a clinical setting.

Cred. Approval: The date the provider was approved by the credentials committee.

MEC Approval: The date the MEC approved the provider.

Board Approved: The date the GB approved the credentialing application and privileges for the current appointment.

Review Complete Date: The date the provider was published. If using Aiva Cycles this date is updated by Aiva. If not, this date must be manually populated.

Temp Privilege Date: The date any temporary privileges were granted to the provider. Manually populated.

Initial Appointment: The date the provider was first appointed. Manually populated.

Advancement1: Used to track internal reviews during provisional appointment period. Manually populated.

Advancement2: Used to track internal reviews during provisional appointment period. Manually populated.

Reapp. Packet Sent: The date the reappointment packet was sent. Manually populated.

Reapp. Application Received: The date the reappointment packet was received from the provider by the MSP. Manually populated.

Last Appointment: The date the provider was last appointed. Manually populated.

Next Appointment: The date in the future when the provider is due for reappointment. Commonly referred to as "Reappointment Date". Manually populated.

OPPE Date: OPPE due date. Manually populated.

FPPE Date: FPPE due date. Manually populated.

File Audit: (formerly titled “Executive Order” when using this field in reports, you must use “Executive Order” then you can modify the

name in the report.) The date the file was audited by another medical staff office employee. It is recommended that every file is audited before it goes through review.

Credentialing Complete: This field is checked once a provider has completed the credentialing process. If not checked, the provider is listed as an Incomplete Application on the home page workflow section. This field can be manually unchecked when the provider is completing reappointment so that their name displays on the home page workflow. Once approved for reappointment, the box would need to be rechecked. When an applicant is archived, the credentialing complete box remains checked.

Department1: The department the provider works in at the facility.

Proctor Removed: The date the proctoring ended.

LOA Expires: The date the leave of absence expires.

Resigned: The date the provider resigned/left. Entering a date that is in the past will prompt the user to *Archive* the record.

Resigned Reason: Reason for resignation (see Section 11 above for resignation designations).

PCP: Whether or not this is a primary care provider. For the IHS, a primary care provider is defined as an MD, DO, APRN, and PA who has privileges in primary or preventative care in the following areas: family medicine, internal medicine, OB/GYN, and pediatrics.

On Staff: Whether or not this provider is/was an applicant. This box should remain unchecked until the applicant has been approved by the GB for their initial appointment. Once initially approved, this box is never unchecked. This allows for the provider to be included on reports, E>Priv, and MD-Query exports.

Archive: Whether or not this provider is archived. If a provider has and should no longer appear in merges, reports, or the main search box, this field is checked. **NOTE**: On-Staff box remains checked when archiving a provider.

Turnaround Times

MD-Staff calculates the average processing time using Application Received and Application Processed. The IHS will utilize additional fields to calculate interval average processing times.

Software: The following fields may be used to collect interval turnaround times:

- Pre-Application Sent
- Pre-Application Received
- Application Sent
- Application Submitted
- Application Received
- Application Type
- Application Status
- Application Processed
- Cred. Approval
- MEC Approval
- Board Approval
- Review Complete Date
- Temp. Privilege Date
- Initial Appointment
- Last Appointment
- Next Appointment
- File Audit

Future Appointments

The creation of a Future Appointment record is triggered automatically when sending out an MD-App reappointment application. Future appointment dates allow users to draft and schedule appointment details to be updated on a given date. Users can update Future Appointment fields for providers' approval dates, appointment dates, and other fields, and then enter an **Effective Date**, notifying MD-Staff when those new dates and values will go into effect. When the **Effective Date** arrives, the Future Appointment record will overwrite the existing appointment record, while simultaneously saving a copy of the past appointment values under the provider's Appointment History page. This allows a provider's current dates to remain current while you simultaneously

process their new reappointment. If using Aiva, as the provider moves through the cycle these dates will be available for publishing in the "Ready to Publish" phase of the Aiva Cycle dashboard. An additional Publish button will be available if your provider does not belong to an Aiva cycle. After your provider's Future Appointment values are updated and populated with all of their new appointment data, and their provider checklist is completed to 100%, click the **Publish** button.

Providers should not have a future appointment column on the appointment page unless they are actively in a reappointment stage.

Standard Work - Approvals/Signatures

Recommendations and approvals in Virtual Committee should include in the final outcome the title and role of the signatory (e.g., Clinical Director, Chair of the MEC)

All signatories should utilize a “recommend” selection with only the Chair of the GB or their designee using the “approval” selection.

Virtual Committee: Once the file is approved in Virtual Committee, navigate to **Credentialing > Virtual Committee** > select the correct LP and Review. Once LP is highlighted, select the **Paper icon > Review Abstract** and save it as PDF to your local drive. Once saved, upload PDF in the LPs Files in MD-Staff **as File Type: Approvals/Signature**, set to Facility, and Description should mirror the appointment year and type, e.g., 2024 Initial Appointment

Paper Signature Pages: Each facility should work with the area office to establish their Virtual Committee Review template method for the Area. If not using Virtual Committee yet, the signed paper signature pages shall be uploaded in the LPs Files in MD-Staff as **File Type: Approvals/Signature** and set to Facility.

Section 13: Credentialing by Proxy

To operate a compliant and successful credentialing by proxy (CBP) program, IHS facilities must abide by the CBP requirements in this SOP, the standards required by their accreditation organization, the facility's medical staff bylaws, and the Medicare Conditions of Participation (CoPs) where applicable. The CBP standard work in this SOP meets the Medicare CoPs requirements, The Joint Commission Hospital and Critical Access Hospital standards for CBP. TJC Ambulatory and Behavioral Health Manuals and the Accreditation Association for Ambulatory Health Care (AAAHC) standards are silent on CBP.

This SOP is used for CBP remote telemedicine practitioners for IHS federal facilities where the accrediting organization does not have standards to address CBP. This SOP does not address the contracted services or contracting requirements, only the required standards, policies, and standard work necessary for the CBP process and documentation in MD-Staff.

CBP does the following:

- increases patient access to enhanced specialized health care services for our very remote facilities;
- reduces the credentialing and privileging burden for the originating site (OS) (where the patient is located) and the clinicians, especially where there are large numbers of physicians or other licensed practitioners providing telemedicine services;
- acknowledges that the OS may have little experience in privileging in certain specialties and that the distant site has more current and relevant information upon which to base its privileging decisions; and
- telemedicine has been shown to reduce the cost of health care and increase efficiency through better management of chronic diseases.

Credentialing by Proxy:

The CBP process provides a path where the OS can accept a Medicare-participating organization (hospital) or a distant site telemedicine entity's (DSTE) credentialing work for remote telemedicine practitioners, rather than requiring the full traditional credentialing process for practitioners who will never physically present to OS facilities.

While it is not required to use the CBP process to credential distant site (DS) telemedicine practitioners, the CBP process has been the agency's

preferred method for credentialing telemedicine practitioners in the IHS since 2012. Practitioners providing in-person or onsite services must be fully credentialed and privileged using the traditional credentialing process.

Standard Work: The elements below outline the CBP process of using the credentialing and privileging decision from the hospital or DSTE to make a final privileging decision for telemedicine practitioners providing telemedicine services for federal IHS facilities.

1. CREDENTIALING BY PROXY WRITTEN AGREEMENT

To utilize CBP, the OS must enter into a written agreement with the Medicare-participating organization or a DSTE that satisfies all CMS final rule CBP requirements. For IHS federal facilities, the Office of General Counsel (OGC), Department of Health and Human Services developed a sample agreement for use. OGC recommends that the agreement be reviewed by the appropriate contracting officer handling the contract to ensure the terms of the contract are not in conflict with the agreement.

The CBP agreement can include one or multiple IHS federal facilities. Review the agreement and consider the services being contracted. Identify if the privileges and services are identified in the agreement or obtain IHS facility-specific privilege forms for each DS practitioner. Then, determine if IHS background checks are required according to the agreement.

2. MEDICAL STAFF BYLAWS

The medical staff must adopt and enforce bylaws that include criteria to determine privileges to be granted to individual practitioners and a procedure for applying the criteria that are subject to §482.12(a)(8)(9) and §482.22(a)(3)(4). The OS has approved bylaws or policies that include language that enables the OS to rely upon the hospital or DSTE credentialing decisions when making their own credentialing and privileging decisions regarding DS telemedicine practitioners.

3. DISTANT SITE ELGIBILITY

Documentation proving that the hospital or the DSTE furnishes services in a manner that enables the OS to comply with all applicable Medicare CoPs for contracted telemedicine services is required. This may include DS accreditation award letter, policies, and procedures related to telemedicine credentialing, etc. The DSTE is a Medicare-participating organization, or satisfies all CMS final rule CBP requirements.

4. SCHEDULE 1 ROSTER

The DS submits a schedule 1 roster and includes all practitioners who have had their credentials verified by the DS and have approved privileges at the DS that will be performed at the OS. Any time providers are removed or added, a new schedule 1 roster needs to be submitted by the DS and approved by the OS GB; both the DS and OS sign and date the roster. The initial schedule 1 roster should not be sent to the OS GB for approval until all DS practitioners listed on the initial schedule 1 have all IHS-required documentation and verifications completed for a CBP provider.

5. DS DECISION NOTIFICATION LETTER

A copy of the DS LP's decision notification letter is required to document that they are currently approved by the DS to perform privileges. The agreement also requires the DS to notify the IHS of any changes in the practitioner's status, credentialing, or privileging.

6. PRIVILEGES

A copy of the DS LP's approved privileges and either 1) a copy of requested IHS area/facility specific privileges, or 2) the agreement has listed the services and specific privileges to be provided by the DS LPs. The OS shall also ensure that the privileges it grants each telemedicine practitioner at the OS site do not exceed the privileges granted to that telemedicine practitioner by the DS.

Example verbiage of a CBP teleradiology agreement that includes the services and specific privileges to be provided: "This contract is to provide teleradiology services for the remote interpretation of medical imaging in X-ray, ultrasound, CT, mammography, and MRI to the IHS facilities listed in this Agreement." CMS requires that the OS maintain a copy of the DS practitioner's privileges. The DS practitioner privileges would be reviewed against the services contracted for, and only the privileges the DS practitioner is approved for at the DS would be approved at the OS. If they do not already exist in MD-Staff, the IHS-requested privileges need to be built in MD-Staff so they can be recorded.

The DS practitioners are often approved for more privileges at the DS than what is contracted for at the OS. As an example, many radiologists may be approved for interventional procedures such as CT guided biopsies, drainage catheters placement and chest tube placements would require written policies for those types of procedures for which

they have privileges. Therefore, it is essential for the IHS to either identify the facility-specific privileges to be provided in the agreement or obtain IHS area/facility-specific privileges. This helps surveyors identify what privileges are facility-specific.

See Medicare requirements below regarding additional information about privileges.

7. MEDICAL LICENSURE

All active and inactive medical state licenses for DS practitioners approved on a schedule 1 must be verified. If the DS verifies all active and inactive medical licenses and the IHS area/facility includes that service in their agreement, the DS agrees. In that case, IHS can rely on the DS state license verifications. Suppose the DS does not verify all active and inactive medical state licenses. In that case, the IHS should collect all active and inactive state license information from the DS and conduct the verifications with documentation maintained in MD-Staff. The DS practitioner must hold a current, active, full, and unrestricted license or registration from a state, the District of Columbia, the Commonwealth of Puerto Rico, or a territory of the United States.

8. NATIONAL PRACTITIONER DATA BANK (NPDB)

Each DS practitioner on the schedule 1 shall be enrolled as a continuous query in the NPDB for the time they are on the schedule 1 with IHS, unless the OS has made the DS an authorized agent, with documentation maintained in MD-Staff.

9. OFFICE OF INSPECTOR GENERAL (OIG) AND SAMS VERIFICATIONS

Each IHS facility where a DS practitioner is approved for privileges shall have OIG and SAM verifications completed, with documentation maintained in MD-Staff.

10. SIGNED IHS PRACITIONER ACKNOWLEDGEMENT & RELEASE

Each DS practitioner must have a signed IHS Conditions of Application and Release Form in MD-Staff.

11. IHS CBP INTAKE FORM

An OMB-approved IHS CBP Intake Form has been developed and is available to send to the DS to provide the information necessary for the practitioner's profile in MD-Staff.

Document Storage in MD-Staff: Since CBP allows facilities to use the credentialing decisions of the DS, a full IHS credentialing application

does NOT need to be completed by the telemedicine LP, and IHS does not require a full credentials and verification process. Please remember that some CBP practitioners in MD-Staff are fully credentialed and privileged at some facilities because either they provide patient care services onsite or the facility chooses not to use the CBP process. Follow the IHS MD-Staff General Documentation Guide to ensure that information is appropriately documented and identify what items are shared (global) or facility-specific across the agency.

The IHS MSP will ensure the following information is collected and maintained in MD-Staff for CBP providers:

1) **Demographic tab (Shared)**
    - **a) First name**
    - **b) Last name**
    - **c) Degree** *(needed for reports)*
    - **d) Salutation**
    - **e) Birth Date**
    - **f) Social Security Number** *(needed for NPDB CQ)*
    - **g) Field of Licensure** *(needed for reports)*
    - **h) Cell Phone**
    - **i) Email Address**
2) **Appointment tab (Facility-Specific)**
    - a) **Application Sent** – Pre-populated by system when MD-App CBP Intake Form is used, otherwise enter the date when the information from the DS was requested.
    - b) **Application Submitted** - Pre-populated by system when MD-App CBP Intake Form is used, otherwise enter the date the information from the DS was provided.
    - c) **Application Received** - Pre-populated by system when MD-App CBP Intake Form is used, otherwise enter the date the information from the DS was put in the system.
    - d) **Application Type** – Select Credentialing by Proxy
    - e) **Application Reason** – Select Staffing Need
    - f) **Application Status** – Select Schedule One
    - g) **Application Processed** – Enter the date the MSP completes all required verifications for CBP (State license, NPDB CQ enrollment, and privileges recorded) and all required documentation (release, DS and OS privileges, schedule 1, and decision notification letter) is received.

h) **Initial Appointment**– Enter date that the provider was first added to the schedule 1 roster by the GB chair, or designee
i) **Board Approval** – Enter date the schedule 1 Roster was last approved by the GB chair, or designee
j) **Last Appointment** – Enter date that the schedule 1 roster was last approved by the GB chair, or designee
k) **Next Appointment** – Enter date of next appointment, also known as reappointment date
l) **Credentialing Complete** – Check this box when the GB has approved the schedule 1 that the practitioner is listed on for the first time.
m) **Status** – Select Associate (Consultant/Courtesy)
n) **Category** – Select Credentialing by Proxy
o) **Department 1** – Choose the department that the provider will be working within (Example: Radiology is the designated department for teleradiologists.) Do **NOT** choose "Telehealth"
p) **Corporate Status** – Choose the name of the telemedicine entity (if the entity is not listed, contact the current national credentialing leads to have it added)
q) **On Staff** – Check this box when the GB has approved the practitioner on the schedule 1. Once this box is checked for any provider, it should never be unchecked.

3) **Address (Shared)** - Add any Addresses to the Address tab
4) **License/Credentials (Shared)** - Add the **state licenses** in the License/Credentials tab and PSV.
5) **Files (Facility or Global – Global are shared)**
    a) **Add the DS Decision Notification Letter (Appointment letter), DS privilege form, Approved Schedule 1, and the requested privilege form for the OS (if OS privileges are not listed out in the Agreement)** for each practitioner in the practitioner's Files section in MD-Staff:
        a. Add
        b. **Type**: Decision Notification Letter
        c. **Facility**: Global
        d. **Description**: Distant Site Appointment Letter

e. **Expires**: Enter the expiration date of the provider's appointment at the DS to correspond with the DS appointment cycle
f. **Upload File**
g. **Save**

2. Set the Expiration date as the expiration date of the DS appointment/privileges.
3. The MSP should set up an alarm in MD-Staff to alert at least 90 days prior to when the provider's DS appointment is about to expire. Note that a new appointment letter and privileges will need to be obtained from the DS for the next reappointment.

b) Review the DS privileges to ensure that the DS provider is not providing services at the OS that is not approved at the DS.

6) **Facility-specific privileges request form** from each individual DS practitioner (if the OS services and privileges are not delineated in the Agreement).
   a) Add the document in MD-Staff: in the Files section of MD-Staff under "Requested Privileges."
   b) Record privileges in MD-Staff the "Record Privileges" section under the Jump To tab.
7) **NPDB Continuous Query**
   a) Store this verification in MD-Staff under Verification Log.
8) **OIG and SAM verification**
   a) Store these verifications in MD-Staff under Verification Log.
9) **IHS Conditions of Application and Release** – signed by the provider
   a) Store this document in the Files section under Statement of Release.

2. The MSP will continue with the normal processes of credentialing and privileging, including the appropriate MEC and GB credentials committee approvals, per the bylaws and agency policy.
3. Background/security checks will comply with the agreement.
4. Once approved, the MSP will enter the facility-specific appointment information into the Appointment tab of MD-Staff, and mark the provider as "Credentialing Complete" and "On Staff."

Quality Assurance and Ongoing Monitoring:

1. The OS will monitor the performance of the practitioners covered by the CBP agreement, including any adverse events and patient/staff complaints, and report these issues to the DS within the time specified in the Agreement.
2. The OS will submit an annual report to the DS to minimally include all adverse events and patient/staff complaints that result from the telemedicine services provided by the DS physician or practitioner to the hospital's patients.
3. The DS will communicate any actions that result in DS practitioners becoming “not in good standing” to the OS within the time specified in the agreement.
4. The DS will provide yearly quality assurance information (these can be summaries) to the OS for individual practitioners to be used in reappointment decisions, covered by the written agreement.
5. The DS will provide an updated accreditation award letter when accreditation is renewed or a letter stating they are a Medicare-participating organization.

Survey Tips

1. Email or call the vendor to alert them to your survey times, so they can be available to assist with any questions or provide any files requested.
2. If asked to see the practitioner’s privileges, show the surveyor the OS privileges or the agreement that list out the services/privileges that the DS practitioners provide at the OS. Only show the DS privileges if asked.
3. Have a copy of the agreement readily available.

CBP Resources:

CMS Medicare Standards

Hospital

The following CMS Condition of Participation: Medical Staff are citations where you can read the standards.

§482.22

§482.22(a)

Distant Site Hospital

§482.22(a)(3)(i-iv) TAG:A-0342 (i-iv)

§482.22(a)(4) TAG:A-0342

Distant Site Telemedicine Entity

§482.12(a)(1) through (a)(7)

§482.12(e)
§482.22(a)(1) through (a)(2)
§482.22(a)(4) TAG:A-0343 4) (a) (1) and (2)
§482.22(a)(4)(i-iv) TAG:A-0343 (i-iv)

Medical Staff Bylaws
§482.22 (c)
§482.22 (c) (6) TAG:A-0363
[The bylaws must:]
(6) **Include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges.** For DS physicians and practitioners **requesting privileges** to furnish telemedicine services under an Agreement with the hospital, **the criteria for determining privileges and the procedure for applying the criteria** are also subject to the requirements in §482.12 (a) (8) and (a) (9), and §482.22 (a) (3) and (a) (4).

Section 14: MSP Training Competencies and Certifications

MSPs, as key support members of the area/facility medical staff team, should seek to increase their knowledge, skills, and abilities to ensure their competencies as the gatekeepers of patient safety. All IHS MSPs should be familiar with the following items:

- Indian Health Manual, Medical Credentials and Privileges Review Process Policy: https://www.ihs.gov/ihm/pc/part-3/p3c1/
    - Indian Health Service Standard Operation Procedures for Credentialing and Privileging (this SOP).
- The area and/or facility's local medical staff bylaws, rules and regulations, and any policies that guide medical staffing.
- The facility's accrediting body chapters, sections, or parts of the accreditation manual that address medical staffing, credentialing and privileging.
- Federal Register Notice Vol.63, No. 144, pages 40297-40300, dated July 28, 1998. This Notice can be found at: www.cms.gov/Research-Statistics-Data-and.../0008-NPS.pdf (see the Department of Health & Human Services, Health Care Financing Administration).
- Request for Records Disposition Authority, DAA-0513-2018-0002
- Corresponding professional service IHM manuals for licensed practitioners, e.g., Dental, Nursing, Physician Assistant, Pharmacy, Behavioral Health, etc..
- Freedom of Information Act, The Privacy Act, HHS System of Records Notice (SORN), SORN 09-17-0003. https://www.hhs.gov/foia/privacy/sorns/09170003/index.html
- Hospitals - Centers for Medicare & Medicaid Services Condition of Participation (CoP).
- National Practitioner Data Bank Guidebook. NPDB Guidebook (hrsa.gov)
- National Association of Medical Staff Services (NAMSS) Credentialing Standards: NAMSS_1260700-23_ICS_Document_UpdateFINAL (1).pdf

In addition, all IHS MSPs should:

- Sign up for the IHS Medical Staff Listserv - https://www.ihs.gov/listserv/topics/signup/?list_id=582
- Join the IHS HQ Credentialing and Privileging SharePoint site - https://collaborate.ihs.gov/sites/QualityAssurance/CredentialingProgram
- Attend the Monthly IHS MSP Office Hours held on the third Tuesday of each month from 4 to 5 pm EST on Microsoft Teams. Reach out to your Area MSP Coordinator or the OQ Credentialing Coordinator to be forwarded the invite.

- Attend the Monthly IHS MSP eLearning Sessions held on the fourth Tuesday of each month from 11 am to 12 pm EST on Microsoft Teams. Reach out to your Area MSP Coordinator or the OQ Credentialing Coordinator to be forwarded the invite.

National Credentialing Certifications

The National Association of Medical Staff Services (NAMSS) certification program establishes industry standards and serves as a comprehensive measure of knowledge in the field, demonstrated through two different credentialing certifications. There are typically three testing periods (spring, summer, and fall) for both certification exams. Candidates are scored as pass/fail using a criterion-referenced method, which allows the performance of each candidate to be judged against a predetermined standard, rather than against other candidates. The passing scaled score is 400 for the CPCS exam and 450 for CPMSM exam.

Can federal agencies pay for employee certifications?

Yes, 5 U.S.C. 5757 allows agencies to pay for professional credentials including professional certification. For more information on certifications, please refer to the Office of Personnel Management

How does taking these certification exams directly benefit me?

Passing the CPCS, CPMSM and/or the MD-Staff Certification Exam will open doors from performance to leadership by:

- Helping your colleagues with questions
- Streamlining your medical office with best practices
- Obtaining more knowledge on credentialing, privileging, and MD-Staff solutions
- Leveraging your annual performance reviews by demonstrating your mastery
- Adding as a mastery skill to your resume and online profiles

National Certifications

The two types of national certification are:

Certified Provider Credentialing Specialist (CPCS®)

Once an MSP has worked in the credentialing and privileging field for at least 12 consecutive months in the last 24 months AND has a total of three years of experience in the medical services profession within the

past five years, the MSP can apply to take the exam. The exam is 150 multiple-choice questions with a 3 hour time limit. IHS MSPs should highly consider taking the exam to obtain the Certified Provider Credentialing Specialist (CPCS®) national certification.

Certified Professional Medical Services Management (CPMSM®)

At the time of application, the candidate must be currently employed in the medical service profession for at least 12 consecutive months within the last 24 months AND have five years of experience in the medical services profession within the past eight years. The exam has 175 multiple-choice questions with a time limit of 4 hours. IHS MSPs should highly consider taking the exam to obtain the Certified Professional Medical Services Management national certification.

Once Certified

Certifications remain current for three years. To be eligible for recertification, single certificates must earn thirty (30) CE credits, and dual certificates must earn forty-five (45) CE credits each recertification period. For single certificates, fifteen (15) of the thirty (30) required hours must be NAMSS-approved credits. For dual certificates, twenty-five (25) of the forty-five (45) required hours must be NAMSS-approved credits.

Verification

To verify those currently holding a NAMSS certification and to identify when renewal dates are due, visit https://www.namss.org/Certification/Certification-Verification

Software Trainings and Certifications

Part of your access to MD-Staff includes a variety of educational resources at no additional cost. Your options include:

- **Self-Paced MD-Staff Academy Courses** - regimented courses that include knowledge checks and a final quiz. Designed to educate and test user retention. These courses are also recommended if you're interested in sitting for the MD-Staff Level 1 Certification Exam.
- **On-Demand Videos** - short videos available in the Help Center. Perfect for quick and specific training.
- **Live Webinars** - hosted weekly by MD-Staff trainers. Ideal environment for networking with other clients and engaging with a live instructor.

- **User Manual** - online user manual contains all the product documentation needed to answer technical or workflow questions. Most articles include step-by-step instruction and screenshots.

For software questions call the ASM Support Team at 1-800-736-7276 or email them at support@mdstaff.com.

Once MSPs become familiar with MD-Staff, IHS highly encourages MSPs to become a MD-Staff Certified User by taking their Level 1 MD-Staff Super User Exam to demonstrate your competency. The exam is meant to test MD-Staff expertise. Even though the exam is open book, it is highly recommended to study before taking the exam utilizing all available resources such as – **Live Webinars**, **MD-Staff Academy Courses**, and Help Center Articles.

Level 1 MD-Staff Super User - The exam is designed to cover all modules to become a super user. Being a super user means that an MSP has extensive MD-Staff knowledge and experience.

Understanding all modules will assist in elevating product knowledge and assisting the medical office to be efficient in navigating software processes.

MD-Staff Certified User - https://www.mdstaff.com/certification-exam-faqs/ There are 180 multiple choice questions (open book), time limit is 2 hours. The candidate must pass at 80% or higher. Two attempts are allowed. There is no wait time between attempts. Typically Applied Statistics Management (ASM) provides two free attempts for MD-Staff user conference attendees,.

https://www.mdstaff.com/md-staff-certification-study-group/ While this study group has ended, the webinar series is still available in MD-Staff Academy.

- **Once certified -** https://learn.asm-inc.com/md-staff-recertification-submission

MD-Staff recertification involves completing a set of requirements within a three-year timeframe. These requirements include a total of thirty (30) courses and/or live webinars. All courses and webinars will be logged on the MDP's MD-Staff Academy Profile. Recertification is essential to maintain and update certification, ensuring that MSPs

maintain current knowledge on with the latest developments in the software.

Level 2 MD-Staff Super User

Forthcoming, not currently available, in development.

Section 15: Frequently Asked Questions

Application FAQs

Q: What is the difference between the human resource application and onboarding, and the medical staff application and onboarding?

A: Within IHS, human resources and medical staff offices operate independently, each adhering to distinct requirements, processes, standards, and regulations. Consequently, all employed LPs undergo two separate onboarding procedures tailored to these different areas. Employed LPs are selected and hired through the HR process. Similarly, contract LP staff engage in both medical staff credentialing and contracting onboarding processes. Contract companies and/or individual contracted LPs are selected and paid through the Acquisitions Department.

Both employed and contracted LPs must pass a background clearance through a personnel security representative and complete the same medical staff credentialing and privileging process.

Medical Staff Process: Applicants and all hired LPs must ensure their licenses, registrations, and certifications remain valid and in good standing. They must inform the CD or their designee within 15 calendar days of any changes that could negatively impact their appointment or clinical privileges. This includes, but is not limited to, new, pending, proposed, and final actions. Failure to disclose such information may lead to administrative or disciplinary measures.

Conditions of Employment: Conditions of employment are required items that the employee must agree to, and qualify for, if hired. Conditions vary from job to job. The job listing or contract will provide a list. A few examples of conditions of employment for LPs may include:

- U.S. Citizenship
- Certain vaccines
- On call hours
- Success in medical staff membership or privileges
- Outcome of background investigation

The inability to meet the conditions of employment for the job means the person no longer meets the requirements to be employed in the position. If an MSP discovers an LP fails to meet a condition of

employment, the MSP should notify the clinical leadership of the finding.

For medical staff, obtaining and maintaining membership and/or clinical privileges is crucial. Failure to secure these upon hire or to maintain them continuously, necessitates consultation with the Office of Human Resources (OHR). This is imperative as such failure may constitute a breach of employment conditions, potentially leading to adverse actions, including termination from federal service.

Q: A provider has already completed an application in the IHS system. The provider has left the first IHS facility and is applying to a second IHS facility. Do they need to complete another application? If so, would it be an initial or reappointment?

A: Yes, the provider will need to complete a new initial appointment application for the second IHS facility. There are multiple reasons for this:

- The application allows the provider to update or add any outdated or new information.
- The application requires the provider to request privileges specific to the facility.
- Credentialing is conducted at the facility level and each facility must independently verify credentials at the time of their appointment and privileging per accrediting organizations and certifying agencies.
- Each MEC and GB must independently review and asses qualifications of each application for appointment and privileging. The MEC evaluates current competency, determines appropriateness of requested privileges, and recommends appointment and privileging decisions based on its own needs, bylaws, and policies.

<u>Appointment/Reappointment FAQs</u>

Q: If a provider allows their reappointment or privileges to lapse, do they have to start over with an initial appointment?

A: Area and service units should follow their own bylaws and policies for this. If the bylaws are silent on this and there are no policy requirements, the provider may utilize the reappointment form and process if the lapse or gap in service is not longer than one year.

Q: Can the GB sign the appointment file and select a date in the future for the privileges to begin?

A: Yes, if the GB makes the notation in their final notes when they sign off on the signature pages in Virtual Committee.

Q: Does IHS credential and privilege residents?

A: It depends. If the LP is a resident moonlighting or completing an unofficial rotation (acting outside of the residency program), then yes, they must be credentialed and privileged.

If the resident participates in an official residency program with a MOU/A at an IHS area/facility. IHS does not require these to be credentialed and privileged unless the MOU/A requires it. However, supervision of the residents and communication with the residency program must still occur. Residents must be "authorized" to provide patient care services in the hospital setting. They start a rotation without any administrative oversight. The MOU/A between the sponsoring institution/program and the IHS site should specify each organization's responsibilities and what type of onboarding documentation will be provided during orientation. The student is not required to be credentialed and privileged. The MOU/A will specify responsibility for the provision of liability insurance.

Q: What types of professions are credentialed and privileged at IHS?

A: The IHS requires credentialing and privileging of medical physicians (MD or DO), Doctors of Dental Surgery or Dental Medicine, Doctors of Podiatric Medicine, Doctors of Optometry, Chiropractors, Advanced Practice Registered Nurses, (IHM 3-4.11), Physician Assistants, Registered Dietician Nutritionists/Registered Dieticians (as approved by the medical staff in the hospital setting per IHM 3.5-4 C.2a), Clinical Pharmacists (IHM 3.7-11 D.), doctorate level clinical psychologists (IHM 3.14-5 8c), Occupational Therapists (IHM 3.15-3 B.2), Physical Therapists (IHM 3.15-3 B.2), Speech-Language Pathologists (IHM 3.15-3 B.2), and any other licensed practitioners identified in the facility's medical staff bylaws.

<u>Contracts/Hiring FAQs</u>

Q. The Tribe contracted/compacted the services of a clinical service, e.g., Dental, Behavioral Health, etc. However, the Tribe still uses the federal facility to provide these services. Who is responsible for the

credentialing and privileging of these providers who now work for the Tribe, but provide care within the walls of a federal facility?

A: The tribe is responsible for credentialing and privileging the LPs they have contracted/compacted for the services they provide.

Q: Is IHS allowed to hire non U.S. citizens for appointment/privileges?

A: For locum tenens read the contract or ask the contracting officer and read the Bylaws. For IHS hires, Human Resources vets the applicants for citizenship.

Q: What is the difference between a family medicine/practice provider and a general medicine provider?

A: The difference between a family medicine provider and a general medicine provider is that a family medicine provider will have completed a 3-year family medicine residency. In general medicine, the provider will only have a one-year residency (transition year), and their privileges are very basic.

Q: Is a contract provider working at IHS eligible for a fee exemption for their DEA registration?

A: No. According to the Office of Diversion Control's (OD) policy regarding the Drug Enforcement Administration (DEA) "FEDDOC" program, only practitioners who are direct employees of a Federal government agency are eligible if they meet the following requirements:

- A FEDDOC practitioner's current official business address must be on his or her DEA application or reapplication form.
- Whenever a FEDDOC practitioner changes his or her official place of business, he or she must request a modification of registration pursuant to 21 C.F.R. § 1301.51, to reflect the location at which he or she is currently practicing.
- A FEDDOC practitioner can only use his or her fee exempt DEA registration for official business while working at a Federal facility.

<u>Documentation FAQs</u>

Q: If a provider works for two staffing agencies, how would the MSP document Corporate Status in the MD-Staff, Appointment section?

A: If the provider works for two staffing agencies, identify which one they work with the most. You can use the comments section on the

Appointment page to add that the provider also works with [Other Company Name].

Q: Can the credentialing software be used to track other professionals that are not credentialed and privileged within the facility that have licenses, registrations or certificates that the facility needs to track?

A: Yes, while not required, if the service unit and/or area requests that certain professionals need to be tracked in the software, ensure the Appointment page lists the appropriate designations in the Category and Status fields so they can be filtered out of credentialed and privileged LPs reports. Health care providers who may have a credentials file maintained in the same system that do not have clinical privileges must be designated as Category "No Privileges" in the software. See Operations Definition Guide on the C&P SharePoint site for additional fields that need to be completed. The most recent guide found in the Standardization > Job aids > Status-Category Switch document.

Q: Can registered nurses and other licensed staff who are not a part of the medical staff be tracked in the credentialing software to take advantage of the software abilities for monitoring?

A: This is an individual area and service unit decision. If tracking non-licensed independent practitioners in the software, they must be entered according to the operational definitions so they can be filtered out for national LP reports.

File Management/Sharing FAQs

Q: When can files be archived from the current credentialing software system?

A: Follow the agency IHM Records Disposition Schedule. Please visit this link: https://www.archives.gov/files/records-mgmt/rcs/schedules/departments/department-of-health-and-human-services/rg-0513/daa-0513-2018-0002_sf115.pdf The Records Management Program (RMP) will be happy to assist in determining what can be destroyed versus what is eligible for storage in a records center. IHS HQ is working with MD-Staff to determine how to manage the data retention tool, which will ensure compliance of the Agency's Records Deposition Schedule.

Q: When LPs ask for credentialing information from their credentialing file, what is the process?

A: For any information the LP provided to IHS, a copy can be provided back to them. Any information or verifications received from organizations or others, including peer references cannot be provided to the LP.

Q: When IHS staff ask for credentialing information from an LPs credentialing file, what is the process?

A: For IHS MSPs, the Sharing Document identifies what documents are to be made Global in the software for sharing. If the IHS employee is not an MSP, but needs the records to perform their official duties, information can be shared per the IHS HQ Privacy Officer.

Q: When individuals outside of IHS ask for credentialing information from a LPs credentialing file, what is the process?

A: The System of Records Notice (SORN) Indian Health Service Medical Staff Credentials and Privileges Records, 09-17-0003 provides categories of disclosures. Please refer all requests for disclosures to the Area Privacy Coordinators or to the IHS HQ Privacy Officer for official determination.

Forms FAQs

Q: Why can't facilities develop their own forms for credentialing and privileging?

A: The Paperwork Reduction Act of 1980 is a United States law requiring federal agencies to obtain approval from the Office of Information and Regulatory Affairs before collecting information from ten or more members of the public, including staff. Within IHS, approval of forms is processed through the Office of Management Services, vetted through the Office of General Counsel, and then to the Office of Management & Budget.

Q. Can privilege forms be used outside of MD Staff? Is it acceptable to email the privilege forms to the applicants for initial applications and reappointments, then upload into the Files?

A: Using paper privilege forms outside of MD-Staff is not recommended. The Agency wants all facilities to fully optimize the software's use, including sending privilege forms with applications to applicants. Use of the software to complete the privilege forms by the applicant allows for less errors in data entry transfers. Once imported, the privilege selections automatically populate in the LPs profile. If it is necessary to

use a paper privilege form, the MSP must also record those privileges in MD-Staff.

Q: Can privilege forms be modified?

A: Yes, privilege forms can be modified. However, modifying active privilege forms will impact any providers with that privilege form. Create a new version of an active privilege form, if the privilege form needs to be modified. Privilege forms have an Effective Date, End Date, and Version number. To create a version, select the option "Create a new version of an existing form." This selection allows for version control.

Q: Can privilege forms from another service unit be used?

A: Yes. Although MD-Staff does not allow users to browse privileges from other facilities, privilege forms may be imported in its entirety or parts of it. Some facilities have provided their privilege forms on the IHS HQ Credentialing SharePoint, or you can ask another service unit for a "X" privilege form on Office Hours. To import privilege forms or parts of a privilege form you can navigate to **Privileges > Privilege Forms > Add a new privilege form.** Once the form is named, other forms can be named within the facility, other facilities, or in the market.
Click **Import** to import privileges. Toggle between related facilities in the **Facilities** field. This allows the user to import privileges from other facilities' privilege forms. Select the appropriate form in the **Forms** field. Once this is done, users will be able to choose which text, criteria, and privileges they would like to add by clicking the plus button.

Licenses/Credentials

Q: Where does it document that licensed independent practitioners can be licensed in ANY state and work for the federal government?

A: Licensure requirements in the IHS are established in Federal personnel regulations and IHS policy circulars:

VII. Licensure Requirements

- PHS Commissioned Corps Personnel Manual, Personnel Instruction 4, Subchapter CC23.3, "Appointment Standards and Appointment Boards"
- Licensure requirements for Civil Service employees can be found at www.opm.gov and searching by discipline, i.e., "physician licensure requirements"

- IHS Circular 95-16, Credentials and Privileges Review Process for the Medical Staff, 12/8/95, revised by Circular No. 96-06, date June 5, 1996.

Tribal programs require caution in interpreting applicability of the federal authority to allow clinicians to practice with out-of-state licenses. If the provider is a federal employee assigned to a tribal program, then the federal rules apply. For clinicians employed by the tribe, attitudes tend to vary among state licensing boards. The best practice for tribal sites is to review the laws of the appropriate licensing board. While a tribe may eventually prevail in a legal dispute over licensing jurisdiction, the provider may be placed in an awkward or risky position. Urban programs, with rare exceptions where a federal employee may be assigned to them, must have clinicians licensed in the local state.

Eligibility Requirements

- US citizenship (Note: Under Executive Order 11935.) Only US citizens and nationals may be appointed to competitive service federal jobs. Exceptions can be made to hire non-citizens as federal civil service employees when there are no qualified US citizens available, unless the appointment is prohibited by statute. Please visit the Office of Personnel Management for more information about citizenship requirements.

Source: http://www.ihs.gov/physicians/index.cfm?module=federal

Q: Where is it documented that a practitioner does not need to be licensed in the state in which they are providing services in a federal facility?

A: Federal licensure requirements in the federal agencies, including the IHS, are established in Federal personnel regulations: https://www.opm.gov/policy-data-oversight/classification-qualifications/general-schedule-qualification-standards/0600/medical-officer-series-0602/

Federal law at 25 U.S.C. § 1621t states that health professionals employed by a tribal health program must only be licensed in a state and are exempt from the licensure requirements of the state where services are performed. The licensure standard for health professionals employed by tribal health programs was made applicable to IHS health professionals pursuant to 25 U.S.C. § 1647a(2). However, § 1647a(2)

goes further to state that IHS employees satisfy state licensure requirements for participation as a provider of health care services under a federal health care program so long as that employee holds a valid license in one state. Federal statutes supersede federal regulations, which include CMS' CoPs.

Q: Are online life support certificates that do not include hands-on training acceptable?

A: Refer to the privilege criteria, bylaws, or facility policies for life support certification requirements.

Board Certification FAQs

Q: What evidence do providers have to provide to prove that they are working on obtaining board certification?

A: Monitoring their board eligibility progress. As long as the LP meets the requirements of eligibility with the specified board, they meet the requirement to be board eligible for IHS.

Malpractice FAQs

Q: How do MSPs respond to requests from outside affiliation regarding FTCA coverage and malpractice history?

A: If outside organizations ask for a claims history or verification of TORT of current or previously employed providers, send the Agency FTCA Letter or direct them to the IHS Risk Management intranet page, Resources | Risk Management (ihs.gov) There is a link that provides information through an agency letter entitled "Outside Requests for FTCA Coverage Verification and Claims History."

This letter explains that IHS providers are covered by FTCA during their time of employment. In addition, provide the requestor with the MD-Query information, and they can log on and obtain the affiliation verification that will list their dates of affiliation with IHS.

Q: Does FTCA cover volunteers in a non-pay status? Such as individuals who choose to practice in IHS facilities due to their specialty and/or desiring to contribute to health care in an underserved population?

A: No, not typically. For specific questions on volunteer coverage reach out to OGC.

Q: Does FTCA cover medical students or residents as part of a graduate medical education?

A: No, not typically. Review the Memorandum of Understanding (MOU) or Memorandum of Agreement (MOA) to identify insurance coverage information. The school will typically provide malpractice coverage through its insurance carrier or through a state tort claims act (for public institutions). For specific questions on volunteer coverage reach out to OGC.

Q: Does FTCA (Federal Tort Coverage Act) cover locum tenens providers?

A: No. Under the FTCA, the federal government acts as a self-insurer, and recognizes liability for the negligent or wrongful acts or omissions of its employees acting within the scope of their official duties. FTCA provides coverage for federal employees not locum tenens providers.

Professional Practice Evaluations FAQs

Q. Can a physician assistant complete chart reviews for a nurse practitioner?

A. It depends on their medical staff bylaws. If not addressed in facility or area medical staff bylaws or policies, PAs and APRNs with similar privileges may perform peer reviews for each other.

Q: How do MSPs report to clinical leadership that providers are participating in ongoing professional practice evaluation (OPPE) and/or focused professional practice evaluation (FPPE) for reappointments?

A: The OPPE/FPPE process is a function of quality departments in IHS. However, there are several ways for quality departments to notify the clinical directors that the provider being reappointed has been participating and the outcomes of the provider's OPPE/FPPE.

Q. Can a APRN and PA provide a peer reference on initial and reappointment applications for each other?

A. No, IHS HQ Office of Quality has reached out to both TJC and AAAHC and they have said that this is not acceptable. If the medical staff office is struggling to find an appropriate peer, it is recommended to find a peer at another service unit and request they complete chart reviews and peer references.

Verification FAQs

Q. If an applicant was contracted/employed with a health system and they provide a verification listing all of the facilities where they held privileges, does the applicant need to list all the facilities separately on the application?

A: Yes, the applicant needs to list all practice history since medical school graduation.

Q. A provider who completed his internal medicine residency in 2019-2022 and is now the chief resident at the same university. Would I verify his chief residency through the Education/Training Verification Form or the Affiliation Verification Form?

A: Since the provider is still in their residency program serving as the chief resident, the Education/Training Form is used and should include all years. If all the years are not covered, verify both.

Q: How should a MSP handle verifying a training program or previous affiliation/employer that has closed?

A: Reach out a previous employer and ask if they were able to obtain verification from the program/employer prior to it closing. You may request a copy of the verification. If they provide a copy of their completed verification, you may use that as secondary source verification.

Q: For an APRN, are registered nurse affiliations verified, or just the APRN experience?

A: Only verify affiliations for APRN experience.

Q: How are credentials that expire managed while the LP's file is in a review process?

A: The MSP will need to verify all expirables upon expiration and place the documentation in the file. The MSP must continue to monitor expirables even during the review process. The MSP must always provide the most current information available.

Q: Is employment at other affiliations within IHS verified?

A: Yes. Use MD-Query. Login credentials and passwords for all IHS facilities are located on the IHS HQ Credentialing SharePoint site.

Q: Can I send affiliation verifications to locum companies to verify on behalf of the hospitals or clinics that the provider is associated with?

A: No. Affiliation verifications must be send/received from the primary source (hospital or clinic) where the provider worked. IHS facilities may obtain a list of facilities from the locum company, but the affiliation verification should be a primary source verification with the affiliated hospital or clinic. If the affiliation is not willing to complete the verification or is non-responsive after 3 attempts, this should be noted as a red flag.

Q: A provider works at an IHS facility, resigns, then is rehired at the same IHS facility. Does the MSP have to fill out an affiliation verification for their facility for this returning provider?

A: No. However, any medical staff-related documentation from their prior employment at the facility should be reviewed by medical staff leadership and/or the hiring official. If available, these documents may include an Exit Clinical Performance Summary and old medical staff documents (credentialing files, professional practice evaluations, etc.)

Appendix

1. IHS Credentialing and Program Government Purchase Card Use Guide
2. Exit Clinical Performance Summary Job Aid
3. NEW Credentialing by Proxy Written Agreement (forthcoming)
4. Initial Appointment Audit Form
5. Reappointment Audit Form
6. Disaster Privilege Audit Form

Appendix 1

IHS Credentialing & Privileging Program Government Credit Card Use with IHS-CEP-MDS

Please read thoroughly before using your IHS-issued Purchase Card in MD-Staff.

IHS recognizes that the ability to use IHS-issued Purchase Cards within the IHS Credentialing Enterprise Program (CEP)-MD-Staff (MDS) optimizes the use of the system, assists in the timely on-boarding of licensed independent practitioners, and therefore supports the mission of IHS. Use of credit cards in the IHS-CEP-MDS system is allowable only if the following processes are followed, with no exceptions:

1) Only Credentialists who are individual purchase card holders can authorize transactions on their cards. Therefore, the credit card cannot be stored for use by multiple people or any other individuals except the cardholder, nor can an individual purchase card holder who is not a Credentialist access the medical staffing files.
2) Cardholders must ensure their purchase card account numbers are masked within the system, are responsible for obtaining spending approvals, as well as keeping track of their spending.
3) Verifications that require payment shall not be set up to run automatically. The card holder must have control over when the card will be charged for a verification.
4) No advance payments are permitted.
5) Single verifications cannot exceed the micro-purchase threshold of $2,500. NOTE: The $2,500 micro-purchase threshold is cumulative within a 12-month period. This means that if the amount exceeds $2,500 within that period, another method of payment needs to be explored and implemented.
6) All other cardholder responsibilities and guidelines apply.

Appendix 2

MD-Staff Job Aid for Exit Clinical Performance Summary (ECPS)

Version	Date	Author	Changes
1	5/25/2023	Christel Svingen	Developed job aid
1.1	8/7/2023	Dione Harjo & Christel Svingen	Included edits/suggestions from NCCMO
2	03/23/2024	Dione Harjo	Expanded section of MD-Staff where to run the pronto out of, added the step of unchecking "In Use" once ECPS Pronto is returned, updated process to reflect that the responsibility lies with the Clinical Director to ensure the ECPS is completed, and to add that the document is internal to IHS and protected.
3	08/02/2024	Dione Harjo	Included information and instructions on the first question on the Pronto **"FOR INTERNAL USE ONLY – DO NOT SUBMIT……"** coming across as Negative in the Verification Log, how to address this in the Verification Log, if needed. Note: Once version 11 is on our servers, this question will be removed and inserted as text with red font, current version does not allow this.

Purpose: The purpose of this job aid is to describe the process to complete the Exit Clinical Performance Summary (ECPS) for credentialed and privileged providers.

Process: When a licensed practitioner (LP) leaves employment with the IHS, a summary of the LPs competency and conduct will be captured on the IHS ECPS at the time of departure by the facility Clinical Director. The CD may designate another individual who is a peer to complete the ECPS, but the CD maintains the responsibility to ensure completion.

The goal is to complete and retain an ECPS for every provider in MD-Staff whose privileges have been voluntarily or involuntarily terminated. This document is an internal document to IHS and is protected by 25 U.S.C. § 1675.

Process:

1. **The MSP will set up a document bundle for their facility so that they are able to send the Exit Clinical Performance Summary pronto:**

   a) In MD-Staff, go to **Setup** -> **Files** -> **Document Bundles**
   b) Click **Add**
   c) Fill in the following fields:
   d) **Edit Bundle Name** – Choose a name for the Exit Clinical Performance Summary Bundle
   e) **Message Template** – Choose Exit Clinical Performance Summary Request
   f) **Available Prontos** – Choose Exit Clinical Performance Summary
   g) Click **Save**

2. **The MSP will set up an entry and electronically send the pronto to the individual who will complete the ECPS:**

   a) In MD-Staff, open the provider's profile
   b) Click on the Other References tab
   c) To set up the entry:
      I. Click **Add**
      II. Fill in the following information:
         1) **Source** – Add your facility
         2) **Email** – Add the email of the individual (Area CMO, facility Clinical Director, MEC designee, or department chief) that will be completing the Exit Clinical Performance Summary Request.
         3) **Type** – Other
         4) **Subject** – Exit Clinical Performance Summary
         5) **Send Method** – Email
         6) **Template** – Choose the template developed for the document bundle
         7) Click **Save**
   d) To send the pronto:
      I. Click once on the entry you wish to send
      II. Click on **Verify**
      III. Click **Verify current reference**
      IV. Click **Send**

3. **The Area CMO, facility Clinical Director, MEC designee, or department chief will complete the pronto:**

   a) The individual completing the ECPS will receive an email notification to complete the pronto
   b) Click on the link at the bottom of the email
   c) Follow the prompts

4. **Once the pronto is complete, save a copy, upload in the provider's Files section as Filet Type – Exit Clinical Performance Summary and set as a "Global" document.**

5. **Navigate back to the Other Reference tab and uncheck the "In Use" checkbox for the ECPS entry** to ensure that the pronto isn't sent again if verifications are automatically completed with any future application imports.

6. **Navigate to the Verification Log. If the ECPS does not have any negative marks, uncheck the negative status. If the ECPS has negative responses regarding the provider's performance, keep the negative status checked Yes.**

Appendix 4

IHS Initial Appointment Audit Form

This Initial Appointment Audit Form is based on the IHM 3-1 policy and SOP requirements. Areas and Service Units may have more strict requirements, but not fewer. This form will be utilized in any IHS HQ audits performed on any initial appointment file audits.

Provider Name:	Service Unit:	Area:

DOCUMENTS / TASKS	Compliant/ Completed?	# NC	Comments
Workflow			
Alarms (appointment, life support, board certification, DEA/CDS, insurance, NPDB, and state license)	Choose an item.		
Summary			
Photo of the provider	Choose an item.		
Demographic			
Degree	Choose an item.		
Salutation	Choose an item.		
Field of Licensure	Choose an item.		
Cycles			
Aiva Cycle selected	Choose an item.		
Appointment			
Application Sent	Choose an item.		
Application Submitted	Choose an item.		
Application Received	Choose an item.		
Application Type	Choose an item.		
Application Status – populated as “One Year”	Choose an item.		
Application Processed	Choose an item.		
Cred. Approval	Choose an item.		
MEC Approval	Choose an item.		
Board Approval	Choose an item.		
Review Complete Date	Choose an item.		
Initial Appointment	Choose an item.		
Last Appointment	Choose an item.		
Next Appointment	Choose an item.		
Credentialing Complete Checkbox Checked	Choose an item.		
Status	Choose an item.		
Category	Choose an item.		
Dept. 1	Choose an item.		
Physical Location	Choose an item.		
Staff Type	Choose an item.		
Corporate Status	Choose an item.		
On Staff Checkbox	Choose an item.		
Dates are in chronological order and make sense	Choose an item.		

Hospitals			
Affiliation PSV complete – last 5 years	Choose an item.		
OMB global verification used or other appropriate PSV	Choose an item.		
Reason for leaving documented	Choose an item.		
Documents 3 unverifiable attempts (name, date of request, and verification methods)	Choose an item.		
No duplicate entries	Choose an item.		
From and To dates are correct	Choose an item.		
Education/Training			
Medical Education PSV complete	Choose an item.		
ECFMG PSV complete	Choose an item.		
Undergraduate Education PSV complete	Choose an item.		
Graduate Education PSV complete	Choose an item.		
Internship PSV complete	Choose an item.		
Residency PSV complete	Choose an item.		
Fellowship PSV complete	Choose an item.		
All Education is listed	Choose an item.		
All Education Types correct	Choose an item.		
Degree listed	Choose an item.		
Subject listed (field of study or focus)	Choose an item.		
OMB global verification used or other appropriate PSV	Choose an item.		
Documents 3 unverifiable attempts (name, date of request, and verification methods)	Choose an item.		
No duplicate entries	Choose an item.		
From and To dates are correct	Choose an item.		
Other References			
Employment PSV complete – 5 years	Choose an item.		
OMB global verification used or other appropriate PSV	Choose an item.		
Documents 3 unverifiable attempts (name, date of request, and verification methods)	Choose an item.		
No duplicate entries	Choose an item.		
From and To dates are correct	Choose an item.		
Peer References			
Peer Reference #1 verification	Choose an item.		
Peer Reference #2 verification	Choose an item.		
OMB global verification used or other appropriate PSV	Choose an item.		
No duplicate entries	Choose an item.		
License/Credentials			
DEA Registration PSV complete	Choose an item.		
DEA Registration expiration correct	Choose an item.		
CDS/DPS PSV complete	Choose an item.		
CDS/DPS expiration correct	Choose an item.		
Active State Licenses PSV	Choose an item.		
Active State expiration correct	Choose an item.		
Inactive State License PSV	Choose an item.		
Inactive State License expiration correct	Choose an item.		

Life Support Certificates attached (not for telehealth)	Choose an item.		
Life Support expirations correct	Choose an item.		
IHS Pain and Addiction Training Certificate attached	Choose an item.		
IHS Pain and Addiction Training Certificate expiration correct	Choose an item.		
All License Types are correct	Choose an item.		
All License/registration fields completed	Choose an item.		
Documents 3 unverifiable attempts (name, date of request, and verification methods)	Choose an item.		
No duplicate entries	Choose an item.		
Board Certifications			
Board Certification PSV complete	Choose an item.		
Board Certification expiration correct	Choose an item.		
Board Certification fields completed	Choose an item.		
No duplicate entries	Choose an item.		
Insurance			
FTCA documented	Choose an item.		
Malpractice Insurance COI – 5 years	Choose an item.		
Current COI includes LP name, dates, and affiliation	Choose an item.		
Minimum of $1M/$3M listed on COI	Choose an item.		
OMB global verification used or other appropriate PSV	Choose an item.		
Documents 3 unverifiable attempts (name, date of request, and verification methods)	Choose an item.		
No duplicate entries	Choose an item.		
Files			
Appropriate Application used	Choose an item.		
Complete Application (all education/training, affiliations, work history, licenses, insurance, etc. listed by provider)	Choose an item.		
Privileges requested by provider	Choose an item.		
Professional Practice Questions Complete	Choose an item.		
Immunization documentation (not for telehealth): • MMR or Immunity • PPD or Quanteferon • Hepatitis B (or declination on application)	Choose an item.		
IHS Conditions of Participation & Release complete	Choose an item.		
OMB Conditions of Participation & Release used	Choose an item.		
Gap Report (no gaps > 30 days or gaps explained)	Choose an item.		
Explanations for negative answers/red flags documented	Choose an item.		
CV/Resume	Choose an item.		
IHS ID Attestation Form	Choose an item.		
CE – previous 2 year, unless post-graduate training completed in prior 2 years	Choose an item.		
File Type names are correct	Choose an item.		
Verifications			
SAM/GSA Verification	Choose an item.		
Medicare Optout Verification	Choose an item.		

NPDB Verification	Choose an item.		
NPI Verification	Choose an item.		
OIG Verification	Choose an item.		
Jump To → View Privileges			
Privileges listed	Choose an item.		
Provider meets all privilege criteria	Choose an item.		
Privileges decision documented	Choose an item.		
VComm			
Recommendations and approvals in VComm should include in the final outcome the title and role of the signatory. All signatories should "recommend" and the GB Chair using "approval."	Choose an item.		
Reviewer & Date Completed:			

 # NC – Number non-compliant/not complete

Appendix 5

IHS Reappointment Audit Form

This Reappointment Audit Form is based on the IHM 3-1 policy and SOP requirements. Areas and service units may have more strict requirements, but not fewer. This form will be utilized in any IHS HQ audits performed on reappointment files.

Provider Name:	Service Unit:	Area:

DOCUMENTS / TASKS	Compliant/ Completed?	# NC	Comments
Workflow			
Alarms (appointment, life support, board certification, DEA/CDS, insurance, NPDB, and state license)	Choose an item.		
Summary			
Photo of the provider	Choose an item.		
Demographic			
Degree	Choose an item.		
Salutation	Choose an item.		
Field of Licensure	Choose an item.		
Cycles			
Aiva Cycle selected	Choose an item.		
Appointment			
Application Sent	Choose an item.		
Application Submitted	Choose an item.		
Application Received	Choose an item.		
Application Type	Choose an item.		
Application Status – populated as “Two Year”	Choose an item.		
Application Processed	Choose an item.		
Cred. Approval	Choose an item.		
MEC Approval	Choose an item.		
Board Approval	Choose an item.		
Review Complete Date	Choose an item.		
Initial Appointment	Choose an item.		
Last Appointment	Choose an item.		
Next Appointment	Choose an item.		
Credentialing Complete Checkbox Checked	Choose an item.		
Status	Choose an item.		
Category	Choose an item.		
Dept. 1	Choose an item.		
Physical Location	Choose an item.		
Staff Type	Choose an item.		
Corporate Status	Choose an item.		
On Staff Checkbox	Choose an item.		
Dates are in chronological order and make sense	Choose an item.		
Hospitals			

Affiliation PSV complete – new since last appointment	Choose an item.		
OMB global verification used or other appropriate PSV	Choose an item.		
Reason for leaving documented	Choose an item.		
Documents 3 unverifiable attempts (name, date of request, and verification methods)	Choose an item.		
No duplicate entries	Choose an item.		
From and To dates are correct	Choose an item.		
Education/Training			
Education PSV complete – new since last appointment	Choose an item.		
All Education Types correct	Choose an item.		
Degree listed	Choose an item.		
Subject listed (field of study or focus)	Choose an item.		
OMB global verification used or other appropriate PSV	Choose an item.		
Documents 3 unverifiable attempts (name, date of request, and verification methods)	Choose an item.		
No duplicate entries	Choose an item.		
From and To dates are correct	Choose an item.		
License/Credentials			
DEA Registration PSV complete	Choose an item.		
DEA Registration expiration correct	Choose an item.		
CDS/DPS PSV complete	Choose an item.		
CDS/DPS expiration correct	Choose an item.		
Active State Licenses PSV	Choose an item.		
Active State expiration correct	Choose an item.		
Newly inactive State License PSV	Choose an item.		
Newly inactive State License expiration correct	Choose an item.		
Life Support Certificates attached (not for telehealth)	Choose an item.		
Life Support expirations correct	Choose an item.		
All License Types are correct	Choose an item.		
All License/registration fields completed	Choose an item.		
Documents 3 unverifiable attempts (name, date of request, and verification methods)	Choose an item.		
No duplicate entries	Choose an item.		
Board Certifications			
Board Certification not expired	Choose an item.		
Board Certification expiration correct	Choose an item.		
Board Certification fields completed	Choose an item.		
No duplicate entries	Choose an item.		
Insurance			
FTCA documented	Choose an item.		
Current malpractice Insurance for contractors not expired	Choose an item.		
Current COI includes LP name, dates, and affiliation	Choose an item.		
Minimum of $1M/$3M listed on COI	Choose an item.		
Documents 3 unverifiable attempts (name, date of request, and verification methods)	Choose an item.		
No duplicate entries	Choose an item.		

Files			
Appropriate Application used	Choose an item.		
Complete Application (all education/training, affiliations, work history, licenses, insurance, etc. listed by provider)	Choose an item.		
Privileges requested by provider	Choose an item.		
Professional Practice Questions Complete	Choose an item.		
IHS Conditions of Participation & Release complete	Choose an item.		
OMB Conditions of Participation & Release used	Choose an item.		
Explanations for negative answers/red flags documented	Choose an item.		
File Type names are correct	Choose an item.		
Verifications			
SAM/GSA Verification	Choose an item.		
Medicare Optout Verification	Choose an item.		
NPDB Query	Choose an item.		
NPI Verification	Choose an item.		
OIG Verification (or NPDB CQ)	Choose an item.		
Jump To → View Privileges			
Privileges listed	Choose an item.		
Provider meets all privilege criteria	Choose an item.		
Privileges decision documented	Choose an item.		
VComm			
Recommendations and approvals in VComm should include in the final outcome the title and role of the signatory. All signatories should "recommend" and the GB Chair using "approval."	Choose an item.		
Reviewer & Date Completed:			

 # NC – Number non-compliant/not complete

Appendix 6

IHS Disaster Privileges Audit Form

This Disaster Privilege Audit Form is based on the IHM 3-1 policy, SOP, and best practices. Areas and service units may have more strict requirements, but not fewer. This form will be utilized in any IHS HQ audits performed on granting disaster privileges.

Provider Name:	Service Unit:	Area:

DOCUMENTS / TASKS	Compliant/ Completed?	# NC	Comments
License/Credentials			
Active State License Verification (Primary source verification of licensure should occur as soon as possible and, at most, within 72 hours from when the volunteer licensed practitioner presents to the facility.)	Choose an item.		
Files			
Proof of Identity - issued by a State, Federal, or regulatory agency of the volunteer.	Choose an item.		
Collect one of the following as evidence of current clinical qualifications: • A current and valid IHS or non-IHS health care facility-issued photo identification. • A current license to practice. • Identification indicating the individual is a member of a Disaster Medical Assistance Team • Identification indicating that the individual has been granted authority to render patient care in disaster circumstances (e.g. authority granted by a Federal, State, or municipal entity), • Attestation by current facility or medical staff member(s) with personal knowledge of the practitioner's clinical qualifications	Choose an item.		
Documentation that the Clinical Director (or equivalent) or CEO authorized disaster privileges	Choose an item.		
Additional Tasks			
Confirm that the facility's emergency operations plan has been activated	Choose an item.		
Confirm plan for oversight of the licensed practitioner's performance	Choose an item.		
Determines and documents that, within 72 hours of the practitioner's arrival, disaster privileges shall continue, if granted	Choose an item.		
The regular application and credentials verification process must be completed as soon as possible for all	Choose an item.		

individuals who received disaster privileges even if an individual's privileges with a facility have already ended			
Reviewer & Date Completed:			

 # NC – Number non-compliant/not complete

Appendix 7

IHS Credentialing by Proxy Audit Form

This Credentialing by Proxy Audit Form is based on the IHM 3-1 policy, SOP, and best practices. Areas and service units may have more strict requirements, but not fewer. This form will be utilized in any IHS HQ audits performed on granting disaster privileges.

Provider Name:	Service Unit:	Area:

DOCUMENTS / TASKS	Compliant/ Completed?	# NC	Comments
Workflow			
Alarms (appointment, life support, board certification, DEA/CDS, insurance, NPDB, and state license)	Choose an item.		
Summary			
Photo of the provider	Choose an item.		
Demographic			
First Name	Choose an item.		
Last Name	Choose an item.		
Degree	Choose an item.		
Salutation	Choose an item.		
Birth Date	Choose an item.		
SSN	Choose an item.		
Field of Licensure	Choose an item.		
Cell Phone	Choose an item.		
Email Address	Choose an item.		
Cycles			
Aiva Cycle selected	Choose an item.		
Appointment			
Application Sent	Choose an item.		
Application Submitted	Choose an item.		
Application Received	Choose an item.		
Application Type – populated as “Credentialing by Proxy”	Choose an item.		
Application Reason	Choose an item.		
Application Status – populated as “Schedule One”	Choose an item.		
Application Processed	Choose an item.		
Cred. Approval	Choose an item.		
MEC Approval	Choose an item.		
Board Approval	Choose an item.		
Initial Appointment	Choose an item.		
Last Appointment	Choose an item.		
Next Appointment	Choose an item.		
Credentialing Complete Checkbox Checked	Choose an item.		
Status – populated as “Associate (Consultant/Courtesy)”	Choose an item.		
Category – populated as “Credentialing by Proxy”	Choose an item.		
Dept. 1	Choose an item.		

Physical Location	Choose an item.		
Staff Type	Choose an item.		
Corporate Status	Choose an item.		
On Staff Checkbox	Choose an item.		
Dates are in chronological order and make sense	Choose an item.		
License/Credentials			
DEA/CDS/DPS PSV (unless DS completes, per agreement)	Choose an item.		
Active State Licenses PSV (unless DS completes, per agreement)	Choose an item.		
Inactive State License PSV (unless DS completes, per agreement)	Choose an item.		
All License Types are correct	Choose an item.		
All License/registration fields completed	Choose an item.		
Documents 3 unverifiable attempts (name, date of request, and verification methods)	Choose an item.		
No duplicate entries	Choose an item.		
Files			
CBP Intake Form completed	Choose an item.		
Privileges requested by provider or included in agreement	Choose an item.		
Professional Practice Questions Complete	Choose an item.		
IHS Conditions of Participation & Release complete	Choose an item.		
CBP written agreement	Choose an item.		
Distant site compliance with Medicare CoP (accreditation award letter, policies/procedures related to CBP, etc.)	Choose an item.		
Schedule 1 Roster signed & dated by both entities	Choose an item.		
Decision letter from originating site	Choose an item.		
List of approved privileges (can be included in agreement)	Choose an item.		
Explanations for negative answers/red flags documented	Choose an item.		
File Type names are correct	Choose an item.		
Verifications			
SAM/GSA Verification	Choose an item.		
Medicare Optout Verification	Choose an item.		
NPI Verification	Choose an item.		
NPDB Query	Choose an item.		
OIG Verification	Choose an item.		
Jump To → View Privileges			
Privileges listed	Choose an item.		
Privileges do not include services at the OS that is not approved at the DS	Choose an item.		
Provider meets all privilege criteria	Choose an item.		
Privileges decision documented	Choose an item.		
VComm			
Recommendations and approvals in VComm should include in the final outcome the title and role of the signatory. All signatories should “recommend” and the GB Chair using “approval.”	Choose an item.		

Reviewer & Date Completed:

 # NC – Number non-compliant/not complete