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

Overview of Manual

The Indian Health Service (IHS) Indian Health Manual (IHM) Part 3, Chapter 1 – *Clinical Credentials and Privileges Program* – references this Standard Operating Procedure (SOP) manual for the credentialing and privileging of all licensed independent practitioners (LPs) authorized to provide patient care at federally operated IHS facilities.

This SOP defines IHS requirements for credentialing and privileging verifications, approved software, and internal control processes to ensure consistency across the IHS healthcare system. It complements IHM 3-1 by promoting an objective, standardized process that supports patient safety through verification of practitioners' competence, character, judgment, education, training, and licensure.

All IHS facilities must implement the standard procedures outlined in this manual and complete an annual assessment and attestation.

This SOP Manual is structured as follows:

Glossary

Accreditation – Refers to the result of an evaluative process in which a healthcare 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 – For the purpose of the SOP, "adverse actions" include "reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in a healthcare entity." A practitioner in good standing should have no employer or work affiliation adverse professional review actions, as defined in the medical staff bylaws.

Affiliation – Places where the LP has or had privileges and may have been a facility's medical staff member.

Distant site (DS) Hospital – The hospital that credentialed and privileged the practitioner providing telemedicine services. The DS may also be the location from which telemedicine services are provided.

Distant Site Telemedicine Entity (DSTE) – The site that provides telemedicine services. See Section 13, Credentialing by Proxy, Distant Site Eligibility.

Executive Committee of the Medical Staff (MEC) – Responsible for reviewing each application for appointments and privileging. The MEC evaluates current competency, determines the appropriateness of requested privileges, and proposes a recommendation through the clinical director (CD) and the chief executive officer (CEO) or their designee to the Governing Body. 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:

- required for all new clinical privilege requests
- as needed for currently privileged LPs in circumstances where privileges or clinic processes change
- as needed for currently privileged LPs to determine the validity of patient care issues or concerns of poor care trends revealed through peer reviews or OPPE.

Governing Body (GB) – The governance authority that manages and oversees the IHS facility. The Governing Body has the authority to grant, modify, or deny medical staff membership and clinical privileges to LPs.

MD-Staff Entry – Credentialing information stored within a tab in MD-Staff. Entries can be added manually or automatically imported from an MD-App credentialing application.

MD-Staff Tab – The area in MD-Staff where credentialing information (entries) are stored in MD-Staff. These include Summary, Demographic, Cycles, Appointment, Address, Hospitals, Education/Training, Other References, Peer References, License/Credentials, Board Certifications, Specialties, Insurance, Medical History, Files, Verification Log, Check List, etc.

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

Ongoing professional practice evaluations (OPPE) – Regularly scheduled assessments of a LP's competency, which seek, per accreditation and regulatory standards, to validate their *current* ability to safely perform the services and procedures they are authorized to carry out through their clinical privileges.

Originating site (OS) – The site where patients are physically located and receive health care services via telemedicine.

Pronto(s) – An online template in MD-Staff that electronically collects verifications from affiliation, peers, education, and organizations.

Primary source verification (PSV) – 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 develop a safe, efficient, and repeatable work method that accomplishes a task while minimizing waste and variability within the process.

Telehealth – A secure audio and/or video telecommunications system that 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 are provided remotely by a practitioner to patients, and consultative services by a DS LP to an OS LP via telehealth technologies.

Unrestricted License – State licenses with no restrictions, special considerations, periods of monitoring, or probationary requirements imposed by a state regulatory authority that in any restricts or negatively impacts the ability of the practitioner to practice his or her profession in the specialty or clinical area for which the practitioner is licensed, certified, authorized or registered, and being hired. This includes any stipulations that may adversely impact patients, the medical staff, or the facility's efficiency.

IHS Applications, Forms, and Tools

All credentialing applications, forms, and tools that require Office of Management and Budget (OMB) approval are identified by an OMB number and expiration date. Aany revisions require OMB reapproval.

Electronic signatures are accepted for all credentialing documents. In the event of software downtime, OMB-approved paper forms may be used. For software procedures, refer to IHM 3-1.3L.

Credentialing Applications and Tools

- Initial Application: Required to be completed for all providers to be considered for an initial appointment.
- Reappointment Application: Required to be completed for all providers to be considered for reappointment.
- Pre-Screen Tool: An optional tool designed to assist service units to identify applicant eligibility according to agency policy and privilege criteria before submitting a full application for medical staff membership and/or privileges. Pre-screens avoid unnecessary application denials and the subsequent obligation to report to the National Practitioner Data Bank (NPDB). Pre-screens may include license verifications, Drug Enforcement Administration (DEA) queries, System for Awards Management (SAM/GSA) Excluded Parties List System (EPLS), Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), and an NPDB query. Provider information submitted through the Pre-Screen tool will autopopulate into an initial appointment application in MD-Staff.
- Credentialing by Proxy (CBP) Intake Tool: An optional tool designed to input LP 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 the Credentialing by Proxy section.
- Additional Privileges Request Tool: An optional tool designed to collect additional requested privileges between appointments.

Electronic Application Completion and Submission: All licensed practitioner (LP) applicants for medical staff appointment and/or clinical privileges must complete the appropriate IHS-designated, OMB-approved *Application for Medical Staff Appointment and/or Privileges* and required supplemental forms. Applications and tools are submitted electronically through IHS's credentialing software, referred to in this manual as "MD-Staff" or "the software." The Medical Staff Professional (MSP) ensures all LP applications are complete and accurate. This includes reviewing, verifying, and analyzing submitted information. Applications require detailed professional history—education, licensure, training, certifications, affiliations, malpractice history, insurance, and attestation/disclosure questions. Each applicant must also request clinical privileges.

Application Authorized Users: Medical staff applications are sent only to the Licensed Practitioner's (LP) email address. If the LP wishes to authorize another individual to assist with the application, they must either grant access through the software or submit a written request including the authorized person's name, relationship, and contact information. This authorization must be uploaded to the LP's MD-Staff profile under Files as File Type "Practitioner Provided." Authorized users may complete the application on the LP's behalf; however, the LP remains responsible for requesting privileges and ensuring the accuracy and

completeness of their application. The “Sign and Submit” screen serves as the LP’s legal attestation that all information provided is true, accurate, and complete, and that no material facts have been omitted.

Application Timing: The full initial appointment application can only be sent to the applicant after they have accepted the tentative job offer. The notice of acceptance of the tentative job offer should come from human resources or may come from the clinical director (CD) or chief medical officer (CMO). For contractors, once the applicant’s profile and CV have been reviewed and approved by the CD or CMO, the initial application may be initiated. It is recommended that reappointment applications be sent at least 90 days before the applicant’s next appointment date.

Complete Applications: Applications are considered complete when all professional education and practice questions have been answered, and the required information has been provided. MSPs 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 with the information they need to make quality decisions. The medical staff professional will notify applicants 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. 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 the necessary 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 Conditions of Application & 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 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.

Unresponsive Applicants or Late Applications: When a request is made for an LP to provide additional information regarding their application, but they are non-responsive, and there is no time limit specified in the local medical staff governance or policies, the LP has 30 calendar days to respond. After 30 calendar days, their application is considered incomplete and ineligible for processing. The applicant must re-submit a medical staff application if they are still interested in pursuing appointment and privileging.

Credentialing Forms

Credentialing forms are used to collect primary source verifications the LP's medical and clinical knowledge, interpersonal skills, technical skills, clinical judgment, communication skills, ability, and professionalism (ACGME Six Core Competencies, as required by the Joint Commission and CMS) as an electronic request through MD-Staff. Types of forms include:

- IHS Peer Reference Pronto: Collects information from peer references and is titled "Peer Reference – Global OMB Approved." This is a required form.
- IHS Affiliation Verification Pronto: Collects information regarding prior work history and is titled "Affiliation Verification – Global OMB Approved."
- IHS Education Verification Pronto: Collects information regarding the LP's medical degrees, specialty training, and completion of residency and fellowship programs and is titled "Education/Training Verification – Global OMB Approved."
- IHS Medical Malpractice Verification Form: Collects information to confirm the LP's current and previous medical malpractice coverage and claims history. The form is titled "Malpractice Verification – Global OMB Approved."
- IHS Conditions of Application and Release Form: A signed release from the LP is required to begin requesting verifications. The signed release form is filed in the Files section. The release can then be attached to Pronto verifications for peer references, affiliations, education/training, insurance, and other verifications.
- Exit Clinical Performance Summary (ECPS) Pronto: The ECPS is completed whenever a credentialed and privileged licensed practitioner (LP) leaves a federal IHS facility. See the Exit Clinical Performance Summary (ECPS) for more information.

Software Processes for Applications, Tools, and Forms

Sending the First Credentialing Application or Tool to a Provider:

1. Initial Check – For every initial application (Pre-Screen and CBP Intake Form) sent, the MSP must confirm whether the LP is already in the system. Not performing this check correctly can result in duplicate provider profiles:
    a. Credentialing > MD-App > New Affiliation and search for the provider by last name (accurate spelling is crucial). Note: If the provider cannot be found, ask if they may have used a different name in the past and search by their prior last name(s.)
    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. If the provider is found, use Step 2 below; if not, use Step 3 below.
2. If Provider is Found:
    a. The provider may have activated MD-Staff Passport. Select the information to autopopulate into the application, if you wish.
    b. Confirm the provider's name and email are correct, then select the Application Template.
    c. If using Aiva Cycles, select the appropriate cycle.
    d. Select the name of the MSP the file will be Assigned To
    e. Add the Checklist

f. Check all General Documents to include (e.g., IHS Conditions of Application & Release and any other facility-type documents that you need to send to the LP)
g. 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.
h. Review your selections, scroll back to the top of the page, and click the Submit button.
i. It is always best practice to confirm that the application was sent successfully. This can be done simply by clicking the Applications option on the left panel. If you do not see your provider's name 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 select 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 match 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 already exist in the system. Select Other Options > Create a New Applicant (not recommended) and proceed.

<u>Sending a Subsequent Application or Tool to a Provider:</u>

1. Navigate to Credentialing > MD-App > Begin a MD-App Reappointment
2. The *Select Provider* window will display. Use the Provider search box to select from the existing providers across all facilities, then click the Next button.
3. After selecting the provider, choose an Application Template to send and select from your General Documents (e.g., IHS Conditions of Application & Release along with any other facility documents) to include with this application packet. *Note: The documents must be uploaded through Set Up > MD-App > Documents to be available on this page.*
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.
6. Note: For Additional Privileges Requests, once the provider submits the Additional Privileges Request through MD-App, ensure the provider selected all previously approved privileges, along with any new privileges. If using Aiva cycles, leave the drop-down blank and then import. After the Governing Body approves, activate the additional privileges in the software keeping the current approved dates of the current appointment. The previously approved privileges and additional privileges will expire at the same time.

Sending a Word Merge Verification Form:

The MD-Staff Insurance tab does not allow for Pronto verifications through the software. To verify the current insurance covering the provider, the MSP must set up 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.

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 a Message Template is unavailable or a current facility-specific one needs to be edited, 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, use the MD-Staff online guides and on-demand videos, or call Support at 1-800-736-7276.

Credentialing Software Fields

The medical staff shall comprise licensed medical staff members 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 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 a minimum, the following medical staff statuses are used to identify LP staff membership in MD-Staff.

A facility's GB can grant several different statuses of medical staff membership. At a minimum, the following statuses are defined in the facility's medical staff bylaws and recorded in the software on the Appointment page.

- Active—Active members of the medical staff, such as physicians, dentists, podiatrists, optometrists, 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.
- Associate (Consultant/Courtesy) – An LP who is a temporary, intermittent, or part-time (less than twenty hours) employee of IHS or a non-IHS employee such as a contractor, locum tenens, consultant, or volunteer practitioner. 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.
- Honorary – A long-term employee and member of the Medical Staff who has been given special compensation to remain a consulting member of the medical staff without patient care responsibilities or privileges. They 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:

- Allied Health – An LP employed by the IHS who does not meet permanent staff (Active) or Associate (Consultant/Courtesy) qualifications. Examples include pharmacists, physician assistants, clinical psychologists, clinical social workers, audiologists, physical therapists, and occupational therapists. Generally, these are non-voting members, with exceptions per facility bylaws.

- Other – Any non-LP employed by the IHS; examples could include non-licensed residents, students, nurses, technicians, or others who do not fit the other category groups. Non-voting members of the medical staff.

Medical Staff Categories

The software uses categories to characterize the LP's time-based relationship with the medical staff. Performance is monitored according to the facility's accrediting body standards and local medical staff Bylaws/policies. This field must be completed to assist HQ in providing reliable reports on LPs.

- Provisional – This "provisional/conditional status" in the credentialing software indicates that the LP's 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.
- Active (Continuous) – Indicates the LP has successfully transitioned off the facility's initial monitoring.
- Credentialing by Proxy (CBP) – Indicates the LP is credentialed by proxy, is listed on a Schedule 1 roster, and has a signed agreement and contract. Additional requirements are spelled out in the CBP section of this manual.
- Emergency/Disaster – Indicates the LP is privileged under time-limited circumstances designated as an emergency/disaster and in adherence with the facility's accrediting body standards, medical staff bylaws, and policies. Disaster privileges are only granted when the facility's Emergency Operations Plan (EOP) has been activated.
- No Privileges – Indicates the employee does not have clinical privileges. This may be employees who hold a license, for which the facility desires to use the software to track for monitoring, accreditation, or non-accreditation purposes.
- Temporary – Indicates that the medical staff has granted a new LP temporary privileges according to and in 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 differentiates employees by the relationship that the LP has with the facility regarding employment. Generally, most federal employees, including 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.

- 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 include CMO, CD, Section Chief, Department Head, and Area Consultant.
- Contractor –
    - 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.
    - Has a contract or agreement (MOU/A) with the local facility. Examples could be Tribal LPs working within a Federal facility, Diagnostic Imaging Associates (DIA), etc.
- Locum Tenens—These individuals are hired through a locum tenens company to provide intermittent services or fulfill patient care needs.

- Permanent Staff – 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.
- Resident – 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.
- Student – These individuals are students from an institution with an MOU/A with the IHS Area/facility, which allows them to learn from LPs and other staff at the facility level.
- Nurse (Non-LIP) – These individuals are current employees and contractors who are not credentialed or privileged and are entered into the electronic credentialing system to track items such as BLS/ACLS, licensure, certification, etc. Examples could include RNs, LPNs, and medical technicians.
- Technician – These individuals are current employees and/or contractors who are not credentialed or privileged but are entered into the electronic credentialing system to track items such as licensure, certifications, etc. Examples could include radiology, ultrasound, lab, or pharmacy.
- Volunteer –
    - Non-medical or healthcare field-focused study students, such as dental, medical, and vision students, volunteer outside any structured MOU.
    - Disaster/Emergency activation allows volunteers to provide services through disaster privilege.

Corporate Status (Employer Type)

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

- Contract Companies (Includes Locum, Tele-Health, Universities, and other contracted service companies). Lists all the companies and/or organizations employees are assigned to. If a company and/or organization is not listed, contact IHSCredentialing@ihs.gov.
- Individual Contractor (Personal Services Contractor)
- IHS - Commissioned Corps
- IHS - Civil Servant
- Tribal MOU/MOA Employee

Physical Location (Work Location)

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

- Choose the location where the LP 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 LPs who do not practice on-site at the facility, select (Non-IHS Tele Med) Exclusively. If they practice on-site and/or are an IHS telemedicine LP, select your facility.
- Please note when running reports and/or setting up displays, the “Physical Location” field will be called “Hospital Based”.

Resign Reason

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

- Assignment Ended: LP’s contract concluded and was not renewed. The status would be marked as “Provider Assignment Ended.” An exit summary is required.
- Deceased: If the LP 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): LP terminated due to a medical staff or personnel action. This situation is designated as “Terminated (with cause).” An exit summary is required.
- Transferred (within IHS): The LP requested a transfer to a different service unit location. The LP's status would be updated to “Transferred (within the organization).” An exit summary is required.
- Tribal Assumption of Operations (638): The LP no longer works at an IHS facility because the IHS facility transitioned to tribal assumption of operations (638). An exit summary is required; best practice is to send the request 90 days in advance of assumption.
- 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: LP ceased to pursue the credentialing process voluntarily. The designation is “Withdrawn.” An exit summary is not required.
- Unfavorable HR/Security: Human resources or Personnel Security Representative 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 LP has been working with a pre-clearance status and the Defense Counterintelligence and Security Agency return an unfavorable result.

Appointment Timeframes

Appointment timeframes indicate how often credentialing and re-credentialing are 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. The 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

Fields indicated with an asterisk (*) are considered standard work and must be completed.

- Pre-Application Sent: Date pre-screen was sent to the LP (if using a pre-screen, this date must be manually populated).
- Pre-Application Received: Date pre-screen was received by the MSP (if using a pre-screen, this date must be manually populated).
- *Application Sent: Date application was sent to the LP. Generated by the system.
- *Application Submitted: Date application was submitted by the LP. Generated by the system.
- *Application Received: Date application was imported by the MSP. Generated by the system.
- *Application Type: The type of application the LP is 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 the LP will begin seeing patients in a clinical setting.
- Cred. Approval: The date the credential committee approved the LP, if applicable.
- *MEC Approval: The date the MEC approved the LP.
- *Board Approved: The date the GB approved the credentialing application and privileges for the current appointment.
- Review Complete Date: The date the LP was published. If using Aiva Cycles, this date is updated by Aiva. If not, it must be manually populated.
- *Temp Privilege Date: The date any temporary privileges were granted to the LP, if applicable. Manually populated.
- *Initial Appointment: The date the LP was first appointed. Manually populated.
- Advancement1: Used to track internal reviews during the provisional appointment period. Manually populated.
- Advancement 2: Used to track internal reviews during the 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 LP by the MSP. Manually populated.
- *Last Appointment: The date the LP was last appointed. Manually populated.
- *Next Appointment: The date the LP 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 another medical staff office employee audited the file. It is recommended that every file be audited before it goes through review.
- *Credentialing Complete: This field is checked once a LP has completed the credentialing process. If not checked, the LP is listed as an Incomplete Application on the home page workflow section. This field can be manually unchecked when the LP completes a reappointment so that their name is displayed 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 in which the LP works at the facility.
- Proctor Removed: The date the proctoring ended.
- LOA Expires: The date the leave of absence expires.
- *Resigned: The date the LP 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 this is a primary care provider. For the IHS, a primary care provider is defined as an MD, DO, APRN, and PA with primary or preventative care privileges in family medicine, internal medicine, OB/GYN, and pediatrics.
- *On Staff: Whether this LP 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 the LP to be included in reports, E>Priv, and MD-Query exports.
- *Archive: Whether this LP is archived. This field is checked if an LP has been archived and should no longer appear in merges, reports, or the main search box. NOTE: The On-Staff box remains checked when archiving an LP.

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
- MEC Approval
- Board Approval
- Temp. Privilege Date
- Initial Appointment
- Last Appointment
- Next Appointment

Future Appointments
Creating 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 LPs' 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 saving a copy of the past appointment values under the LP's Appointment History page. This allows an LP's current dates to remain current while you simultaneously process their new reappointment. If using Aiva, as the LP 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 LP does not belong to an Aiva cycle. After your LP's Future Appointment values are updated and populated with their new appointment data and their LP checklist is completed to

100%, click the Publish button. LPs 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 (preferred method) will include in the 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.
- All documented approvals using the paper approval method will be uploaded into the Files tab under *Approvals/Signature*.
- Archive the completed Virtual Committee, once completed.

As best practice, although not required, once the file is approved in Virtual Committee:

1. Navigate to Credentialing > Virtual Committee > select the correct LP and Review
2. Once LP is highlighted, select the Paper icon > Review Abstract and save it as a PDF to your local drive.
3. 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

Credentials Verification Processes

The credentialing verification process confirms that applicants possess the necessary qualifications, training, experience, and authority to practice within their requested privileges. This section outlines the minimum requirements for credentialing verification elements and corresponds with the IHM 3-1.5 Medical Staff Credentials, Verification of Documentation. General verification guidance is found at the end of this section.

This section is structured in the following format for each essential credentialing element:

- Verification Element
- Standard Work Element
- Acceptable Verifications
- Software Processes

The credentials review process minimally requires the collection, analysis, and verification of the following essential credentialing elements.

1. PROOF OF IDENTITY

Verification Element – Proof of Identity

Verifying that the licensed practitioner (LP) providing patient care is the same individual credentialed is essential for patient safety and compliance. Due to risks of identity fraud, accrediting bodies require this verification, which may be completed by the MSP, clinical director, chief of staff, or designee.

For facilities using credentialing by proxy (CBP) for telehealth LPs, identity verification is the responsibility of the distant site per the CBP agreement.

A recent LP photo must be uploaded to the Demographic tab to support E>Priv and Virtual Committee reviews, so staff can verify that the person presenting to provide services is the same person who has undergone the credentialing and privileging process.

Standard Work Element – Proof of Identity

- At the initial appointment, the LP's identity is verified before the LP provides patient care.
- The verification is documented on the IHS ID Attestation Form and stored in the Verification Log as "IHS Identity Attestation Form."
- At reappointment, identification verification is not required.

Acceptable Verifications – Proof of Identity

Acceptable proof of identity includes a valid, unexpired state or government-issued photo ID (e.g., driver's license, passport, or military ID). Verification must occur in person or via live audio-video communication; copies submitted without such verification are not acceptable.

Software – Proof of Identity

- Upload the IHS ID Attestation Form to the LP's Verification Log labeled "IHS ID Attestation Form:"
  - Received Field: the date the ID is verified.
  - Method**:** Select "ID – In Person" for face-to-face verification or "Telecommunication Video w/Audio" for virtual verification. Do not share ID attestations between facilities unless a formal centralized credentialing office exists.
- It is recommended not to store copies of an LP's government-issued photo ID in the credentialing software to help prevent identity theft. For AAAHC facilities, a current state license must be obtained (CPV.140.30)

2. PROFESSIONAL EDUCATION AND POST-GRADUATE TRAINING

Verification Element – Professional Education and Post-Graduate Training
LPs must hold a valid diploma from a professional school accredited by a nationally recognized accrediting body for their professional discipline. A degree and postgraduate training alone do not confer a license to practice.

The Education Commission for Foreign Medical Graduates (ECFMG) and its organizational members define an International Medical Graduate (IMG) as a physician who earned a medical degree from a school outside the United States or Puerto Rico, regardless of citizenship. U.S. citizens graduating from foreign schools are considered IMGs and require ECFMG certification; non-U.S. citizens graduating from U.S. or Puerto Rico schools are not. Canadian medical graduates on or after July 1, 2025, are also considered IMGs and must obtain ECFMG certification. ECFMG certification verifies the equivalency of medical education and is required for entry into U.S. graduate medical education and for unrestricted licensure in most states.

Providers with Fifth Pathway certificates seeking initial appointment will be referred to the Agency Clinical Credentials Committee (ACCC) for an endorsement determination before the Governing Body considers them.

Standard Work Element – Professional Education and Post-Graduate Training
- At the initial appointment, the applicant's qualifying degree (domestic or foreign) and any post-graduate training, such as internship, residency, fellowship) will be verified. The qualifying degree is the degree required for the applicant's position and privileges.
- At reappointment, verify any new education or post-graduate training completed since the last appointment if it is the qualifying degree or is required for the position or privileges.

Acceptable Verifications – Professional Education and Post-Graduate Training
- Primary sources:
  - The college/university or program, training schools or residency training programs, state medical boards, etc., if the source is a primary source for education and training verifications.
  - OMB-Approved IHS Education/Training Verification: When requesting verification directly from a school or training facility, use the OMB-approved IHS Education/Training

Verification Pronto or Form. A facility-specific verification is acceptable if it includes all information required by the OMB-approved form.

- Designated equivalent sources:
  - Facilities may use the American Medical Association (AMA), American Osteopathic Association (AOA), Education Commission for Foreign Medical Graduates (ECFMG), Federation of State Medical Boards (FSMB), National Student Clearinghouse (NSC), etc., if the source is a designated equivalent source for education and training .

Software – Professional Education and Post-Graduate Training

LPs must list all domestic and foreign education and postgraduate training on the MD-App application, even if incomplete. MD-Staff entries must include institution name, location, attendance dates, degree, and completion status. All withdrawals, leaves of absence, and disciplinary actions must be disclosed and explained.

- Education and training verification documents are attached to the matching entry in the Education/Training tab:
  - 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 degree (i.e. PhD.)
    - Medical Education: education completed for a medical degree
    - 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 degree awarded: Associate, Bachelor, Master, or Doctor. If no degree was earned, choose "No Degree." Leave it blank if the entry is for a fellowship, residency, or internship.
  - Subject: Add the field of study, topic, or concentration focus during the education or training.
- Ensure that the *From* and *To* dates for entries within the Education/Training match verifications to assess time gaps appropriately through the Gap Report.
- Refer to Subsection 3 for verification procedures (automated or manual) and Subsection 2 for guidance on duplicate entries, shared tabs, verification attempts, and unfavorable findings.

3. EXPERIENCE (HOSPITALS AND OTHER REFERENCES)

Verification Element – Experience (Hospitals/Other References)

Experience is reviewed to confirm current competency. Information provided by the LP is compared with their CV/resume and verifications. Any discrepancies require a written explanation or an update to the unimported application. Resolving timeline differences may prompt further verification of affiliations or

employment. The LP must explain any gaps over 30 days since earning their qualifying degree (see Time Gaps). The following experience types appear under the Hospital or Other References tab:

- **Hospital Affiliations**: Any facility where the LP has or had privileges and/or medical staff membership.
- **Employment**: Any facility an LP has worked at but does not hold privileges or a medical staff membership. This includes full-time, part-time, temporary, and volunteer positions. Employment includes facility name, location, position, dates of employment, supervisor name, contact information, and the reason for leaving.
- **Teaching**: Places where the LP has held a teaching position. Includes source and dates.
- **Military**: Military assignments. Includes source and dates.
- **Gap**: A time period greater than 30 days in an applicant's training or experience since graduation from medical/professional school. Includes dates.
- **Other**: All other types of experience that do not fit the above categories. Includes source and dates.

Standard Work Element – Experience (Hospitals/Other References)

- At the initial appointment, verify relevant experience—including affiliations, work history, and military service—for at least the past five years (or further if inconsistencies exist) to assess current competency. For locum tenens or telemedicine LPs (not credentialed by proxy) with extensive experience, verify at least five affiliations in the past five years.
- For reappointments, all active affiliations since the last appointment will be verified to ensure good standing.

Acceptable Verifications – Experience (Hospitals/Other References)

- Completed OMB-approved IHS Affiliation Verification Pronto or Form:
  - When sending verification requests directly to facilities, use the OMB-approved IHS Affiliation Verification Pronto or Form.
  - Employment sources may omit irrelevant questions (e.g., privileges or medical staff) on the form; this is acceptable.
- Affiliation letter from the facility or designated verification website (affiliations where the LP was credentialed and privileged):
  - Organizations may provide a site-specific verification document (e.g., an affiliation letter) instead of the Pronto or Form. IHS service units or areas must determine if it sufficiently assesses the LP's experience and may need to request additional details on competency, behavior, or status.
  - Designated verification website examples may include MD-Query and NAMSS Pass.
- Employment history verification (employed but not credentialed and privileged):
  - Organizations may use software, websites, or other documentation for employment verification. If this is their required method and staff cannot provide direct information, this verification is acceptable.
- Completed DD-214:

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

Software – Experience (Hospitals/Other References)
LPs submit a complete list of all part-time and full-time affiliations, employment, teaching, military, gaps, and other work history on the MD-App credentialing application. The information must include the facility name, location, affiliation dates, medical staff status, reason for leaving, and facility contact information, as applicable. LPs must disclose and explain any instances of discipline, suspension, probation, or reprimand.

- The Hospitals tab includes hospital affiliation information and verifications.
- The Other References tab includes all employment, teaching, military, gaps in employment, or other work history information and verifications.
- Ensure that the *From* and *To* dates for entries within the Hospitals and Other References match verifications to assess time gaps appropriately through the Gap Report.
- See Subsection 3 for instructions on how to complete an automated or manual verification. See Subsection 2 for information about duplicate entries, shared MD-Staff tabs, verification attempts, and unfavorable findings.

4. TIME GAPS

Verification Element – Time Gaps
A time gap is a period of 30+ days after graduation from medical school, during which the LP is not in school, training, military service, teaching, working, or volunteering. Gap explanations can reveal important background details for credentialing. IHS recognizes gaps may result from personal circumstances (e.g., disability, family care). If unexplained gaps are found, compare the application with the CV/resume to ensure completeness. Credentialing software can generate a Gap Report, though service units may use other methods to assess gaps.

Standard Work Element – Time Gaps
- At the initial appointment, review any time gaps over 30 days. Ensure they are documented and explained on the initial application or in a supplemental statement.

Acceptable Verifications – Time Gaps
- Verification of time gaps is not required, but an explanation is.

Software – Time Gaps
LPs must report and explain any time gaps over 30 days since graduation Applications with unexplained gaps should be returned as incomplete.

- Time gaps are documented in the Other References tab as *Gap* under *Type*.
- An optional Gap Report may be completed at the initial appointment. (Gap Report ties to entries on Education/Training, Hospitals, and Other References tabs.)

  - Navigate to *Credentialing -> Reports -> Gap Report*
  - Select the *Names* tab and enter the LP's name
  - Select *Run*
  - Save the file in a PDF and assess for gaps
  - File in the LP's Files tab under *Gap Report*
- "Verify that From and To dates for Hospitals, Education/Training, and Other References align with source verifications to ensure accuracy and identify time gaps in the Gap Report."
- See Subsection 2 for information about duplicate entries, shared MD-Staff tabs, and unfavorable findings.

5. BOARD CERTIFICATION AND PROFESSIONAL AFFILIATIONS

Verification Element – Board Certification and Professional Affiliations
MSPs will review facility privilege criteria and conditions of employment (position descriptions for IHS employees and contracts for contractors) to verify that the LP meets board-certified or board-eligible (BC/BE) requirements. Any discrepancies will be reported to clinical leadership, who must ensure the LP's BC/BE status aligns with requested privileges.

Medical Doctors (MDs) and doctors of osteopathy (DOs) providing care in the IHS must be BC, BE, or exempt. Exempt LPs are those appointed before 10/01/2026 who remain in good standing per peer review and Exit Clinical Performance Summary (ECPS). "Board Eligible" refers to the period before initial specialty or subspecialty certification, typically lasting 3–7 years, depending on the member board.

Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs) must hold and maintain board certification throughout their IHS employment. See the Indian Health Manual, Chapters 4 and 28, for details.

Standard Work Element – Board Certification
- Board Certification:
  - Beginning 10/01/2026, MDs and DOs will be board-certified, board-eligible, or exempt.
  - At initial appointment, (active and inactive) board certifications are verified.
  - At reappointment, verification is only required if the certification is expiring.
  - Board certifications are verified before expiration.
  - Verification of professional affiliations and medical society memberships is not required.

Acceptable Verifications – Board Certification
- Primary sources:
  - Verified through the certifying board.
- Designated equivalent sources:
  - Designated equivalent sources, such as the American Board of Medical Specialties (ABMS), CertiFACTS, AMA, AOA, American Board of Physician Specialties (ABPS), American Nurses Credentialing Center (ANCC), National Commission on Certification of Physician

Assistants (NCCPA), or other nationally recognized certifying body, if the source is a designated equivalent source for board certification verifications.

Software – Board Certification

LPs must list all active and inactive board certifications (board name, certification number, original and recertification dates, and maintenance participation, if applicable) on the MD-App credentialing application and disclose any discipline, suspension, probation, or reprimand.

- When a board certification expires or becomes inactive, its status is updated to Inactive or Expired, and the "In Use" box is unchecked.
- All active and inactive board certifications are recorded in the Board Certifications tab. (State licenses are listed in the "License/Credentials" section.)
- The following types appear under the Board Certifications tab:
  - Board: Name of the certifying Board
  - Specialty: Specialty the board certifies
  - Certified In: Sub-specialization of that Board
  - Cert. Number: Board certification number
  - Exam Date: The date the exam was taken or scheduled to be taken
  - Initial Date: The date the board certification was initially awarded
  - Expiration Date: The date the board certification expires or the date the board eligibility expires.
  - Re-Verify Date: If a board does not issue certifications with an expiration or end date, the recommended renewal date can be added and managed in this field. For these certifications, the Expiration Date field can be left blank.
  - Status: The LP's current status with the Board.
  - Lifetime: Check marked if the board certification is a lifetime certificate (if so, the expired field does not need to be populated).
  - Maintenance of Certification: Check marked if indicated on the verification that the LP is meeting maintenance of certification requirements
  - Re-verify: The recommended date for a lifetime certification to be re-verified if listed.
  - Primary: Check marked if the board certification is the LP's primary board certification.
- Professional affiliation and medical society membership information from the MD-App credentialing application is documented in the Additional Items tab under *Medical Societies*.
- See Subsection 3 for instructions on how to complete an automated or manual verification. See Subsection 2 for information about duplicate entries, shared MD-Staff tabs, verification attempts, and unfavorable findings.

6. LICENSURE

Verification Element – Licensure

Each licensed practitioner providing care in federal facilities must hold a current, active, full, and unrestricted license from a U.S. state, territory, D.C., or Puerto Rico. Licenses define practice scope,

though facilities may further restrict it. Any surrendered or sanctioned licenses will be investigated with the licensing entity and NPDB.

Standard Work Element – Licensure

- At the initial appointment, all active and inactive medical licenses are verified.
- At reappointment or when requesting new privileges, all active licenses are verified.
- Licenses are verified before expiration.
- For providers credentialed by proxy (CBP), only one active state license is verified.

Acceptable Verifications – Licensure

- Primary sources:
  - Verified through each state licensing board.
- Designated equivalent sources (DES):
  - DES are acceptable, such as the Federation of State Medical Boards (FSMB.)

Software – Licensure

LPs must list all active and inactive licenses and registrations (state, type, and number) on the MD-App application and disclose any discipline, suspension, probation, or reprimand.

- For active licenses that become inactive, the *Type* will be changed to *Inactive State License*, and the *In Use* box will be unchecked.
- All active and inactive state licenses are documented in the License/Credential tab:
  - Licensure Board: Name of state licensing board
  - License Type: *State License* for active and *Inactive State License* for expired licenses.
  - License Sub Type: The license subtype, for nursing staff only
  - License Number: License number assigned by the licensure board
  - State: The state granting the license
  - Limitations: Any license limitations
  - Comments: Comments regarding the license
  - Issued: Date the license was issued
  - Expired: Date the license expires
  - Status: License status
  - In Use: Determines whether the license is in use. Check for *In Use* for active licenses and uncheck for inactive licenses.
- See Subsection 3 for verification instructions and Subsection 2 for details on duplicate entries, shared MD-Staff tabs, and unfavorable findings.

7. DRUG ENFORCEMENT ADMINISTRATION (DEA) REGISTRATION AND STATE DEPARTMENT OF PUBLIC SAFETY (DPS) AND CONTROLLED DANGEROUS SUBSTANCE (CDS) CERTIFICATIONS

Verification Element: DEA, DPS, and CDS – LPs may or may not hold DEA registrations, DPS, and CDS certifications.

Standard Work Element – DEA, DPS, and CDS

- At the initial appointment, all active DEA, DPS, and CDS registrations and certifications – and inactive ones if verifiable – are checked.
- At reappointment, all active DEA, DPS, and CDS registrations and certifications are verified.
- DEA, DPS, and CDS registrations and certifications are verified before expiration.

Acceptable Verifications – DEA, DPS, and CDS

- Primary source:
  - DEA registrations will be verified through the DEA website, and DPS and/or CDS will be verified through the appropriate state websites.

Software – DEA, DPS, and CDS

LPs must list all active and inactive DEA, DPS, and CDS registrations and certifications (state, type, and number) and disclose and explain any discipline, suspension, probation, or reprimand.

- All active and inactive DEA, DPS, and CDS registrations and certifications are documented in the License/Credential tab:
  - Licensure Board: Name of state licensing board
  - License Type: The appropriate active or inactive DEA or CDS option
  - License Number: License number assigned by the licensure board
  - State: The state granting the license
  - Limitations: Any license limitations
  - Comments: Comments regarding the license
  - Issued: Date the license was issued
  - Expired: Date the license expires
  - Status: License status
  - In Use: Determines whether the license is in use. Check for *In Use* for active licenses and uncheck for inactive licenses.
- For any active DEA, DPS, and CDS registrations and certifications that become inactive, the *Type* will be changed to *Inactive DEA* or *Inactive CDS*, and uncheck the *In Use* box.
- See Subsection 3 for verification instructions and Subsection 2 for information about duplicates, shared MD-Staff tabs, verification attempts, and unfavorable findings.

8. CURRENT COMPETENCY

Verification Element – Current Competency

All LPs providing 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 education, training, affiliations, peer references, and licensure. These verifications ensure a comprehensive proficiency assessment.

Standard Work Element – Current Competency

- As noted in the IHM 3-1.2 D, E. (6), F current competency is determined by clinical leadership, not the MSP.

Acceptable Verifications – Current Competency

- Verification of current competence includes obtaining assessments, references, and evaluations from sources with firsthand knowledge of the LP's current (within two years) competency, character, training, education, and judgment. This may include, but is not limited to, feedback from peers, supervisors, other healthcare professionals, and organizations who have directly observed the LPs work, along with relevant education, training, courses, etc.
- After privileges are approved, the LP's competence is further confirmed through a focused professional practice evaluation (FPPE) and ongoing professional practice evaluation (OPPE), which systematically evaluate performance to ensure compliance with standards of care.

Software – Current Competency

Current competency is documented in multiple locations in the software.

9. IHS CONDITIONS OF APPLICATION AND RELEASE

Verification Element – IHS Conditions of Application and Release

The IHS Conditions of Application and Release Form is required for all LPs seeking to be credentialing and privileging at IHS facilities. It authorizes IHS to inquire and verify the LP's competence, character, judgment, education, training, and licensure with external sources.

Standard Work Element – IHS Conditions of Application and Release

- LPs must complete the IHS Conditions of Application and Release Form at initial appointments and reappointments. However, a signed IHS Conditions of Application and Release may be used from another facility if the provider signed the form in the last 12 months. If the signature on the form from another facility is greater than 12 months old, a new IHS Conditions of Application and Release must be collected.
- Electronic signatures are acceptable.

Acceptable Verification – IHS Conditions of Application and Release

- The LP has signed and dated the IHS Conditions of Application and Release Form.

Software – IHS Conditions of Application and Release

The completed form is filed as IHS Conditions of Application and Release in the Files section. Add your facility name and the date of signature to the File description. Uncheck "In Use" for any other active IHS Conditions of Application and Release forms.

10. CONTINUING MEDICAL EDUCATION (CME) OR CONTINUING PROFESSIONAL EDUCATION (CPE)

Verification Element – CME or CPE

Documentation of an LP's continuing education (CME, CPE, or equivalent) is required to assess current competency. In addition to initial appointment and reappointment, it may be collected as defined by local medical staff bylaws or accrediting body requirements, which may align with clinical privilege criteria or state licensure standards.

Standard Work Element – CME or CPE

- At initial appointment, collect continuing education from the past two years, unless the LP completed post-graduate training within that period.
- For reappointment, collect continuing education completed since last appointment.

Acceptable Verifications – CME or CPE

Continuing education does not need to be primary source verified. Copies of certificates, summary logs, provider attestation, or continuing education records are acceptable documentation.

Software – CME or CPE

LPs submit copies of certificates, summary logs, provider attestation, or continuing education records, which are filed under the Files tab as Continuing Education.

- Facilities may track the IHS Essential Training on Pain and Addiction in MD-Staff, storing certificates in the License/Credentials tab. If the applicant is not required to complete the training, enter "Exempt" in the License Number field.

11. PROFESSIONAL PEER REFERENCES

Verification Element – Professional Peer References

Professional peer references assess an LP's medical and clinical knowledge, interpersonal skills, technical skills, clinical judgment, communication skills, ability, and professionalism (ACGME Six Core Competencies). Facilities follow their accrediting body's standards for peers. Without accrediting body standards for peer references, the IHS defines a peer as a practitioner in the same clinical discipline and:

- Peer references must come from professionals who have worked directly with the applicant within the past two years and can attest to their competency and character.
- Peers may be from the same organization or an outside entity, but cannot be a relative, spouse, or partner.
- It is highly recommended to obtain one reference from the training program director, department chair, or chief of staff of recent graduates.
- If a facility lacks a discipline-specific peer, another IHS LP with similar credentials at another facility may conduct chart reviews and complete the peer reference.

Standard Work Element – Professional Peer References

- IHS policy requires the collection of at least two peer references at initial appointment. The accrediting body, medical staff bylaws, or area/service unit policies may require more.
- IHS policy does not require peer references at reappointment; however, facilities must follow accrediting body, medical staff bylaws, and area/service unit policies. Peer references are often used at reappointment to confirm current competency.

Acceptable Verification – Professional Peer References

- The OMB-approved IHS Peer Reference Pronto or Form must be used when sending verification requests to peer references.

Software – Professional Peer Reference Requirements

LPs submit professional peer reference information on the MD-App credentialing application. Information includes name, degree, dates of professional association, relationship, and contact information.

- Professional peer reference information and verifications are documented in the Peer References tab.
- **Note:** CMOs/CDs and other credentialed LPs with MD-Staff CMO/CD access should not have their completed Peer Reference forms attached to their Peer Reference tab to maintain confidentiality of the reviewers.
- See Subsection 3 for verification instructions and Subsection 2 for information about duplicates, shared MD-Staff tabs, verification attempts, and unfavorable findings.

12. NATIONAL PROVIDER DATABANK (NPDB)

Verification Element – NPDB

The NPDB database is a federal database operated by the Department of Health and Human Services. The Health Resources and Services Administration established by Congress. It collects reports from health entities, providers, and suppliers, including federal agencies, regarding medical malpractice payments, clinical privilege actions, civil judgments, criminal convictions, and other adverse actions related to healthcare LPs. The NPDB serves as a key resource for verifying practitioners' credentials and disciplinary history.

- Receiving Reports: The following outlines the steps IHS will take when the NPDB sends a new or updated report with findings or comments:
  - The NPDB will email the facility's databank administrators within 24 hours when an LP is enrolled in NPDB CQ and a new or updated report is filed on the LP account.
  - Immediately, upon notification of a report, the NPDB Databank Administrator will obtain the new or updated report and notify the CD and Area CMO of the NPDB report. The report must be sent via Secure Data Transfer, not regular email.
  - NPDB-related actions should be recorded in the MEC minutes to ensure a clear recording of decisions while maintaining confidentiality consistent with NPDB and privacy regulations.
- Filing NPDB Reports: The MSP should review the NPDB Guidebook and Reporting Requirements, to guide clinical leadership on reporting obligations. For assistance, contact the NPDB Customer Service Center (1-800-767-6732) and consult Area OGC attorneys. The ACCC also provides internal reporting guidance.
- NPDB Administrators: At least two employees at each service unit should be designated as NPDB administrators to ensure timely notification of receipt of reports.

Standard Work Element – NPDB

- Each LP will have an NPDB query reviewed during initial appointment or pre-screen (if applicable), at reappointment, and when requesting new privileges. All query reports will be uploaded into the credentialing software.

- Once the LP's initial appointment and/or privileges are approved, the LP is enrolled in an NPDB Continuous Query (CQ) until they exit the system.

Acceptable Verifications – NPDB
The NPDB query report must list the requesting facility's name. Areas using centralized credentialing should contact the NPDB to confirm proper setup and compliance.

Software – NPDB
NPDB query reports not verified through the software must be uploaded to the LP's Verification Log as outlined below:

  - 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: Who verified/enrolled the LP in the NPDB CQ
  - Info Received: Checkmark if a copy of the NPDB is received
  - Mark As Negative: Checkmark if there are any reports listed
- See Subsection 3 for instructions on how to complete an automated or manual verification. See Subsection 2 for information about unfavorable findings.

13. LIFE SUPPORT CERTIFICATES

Verification Element – Life Support Certificates
Basic Life Support (BLS) certification is required for all onsite LPs to ensure life-saving proficiency. LPs with advanced certifications (e.g., ACLS) are exempt from maintaining BLS. Telemedicine or offsite LPs are not required to hold life support certifications. Additional certifications may be required facility bylaws, policies, and privilege criteria.

Standard Work Element – Life Support Certificates
- Copies of all active certifications are required at the initial appointment.
- All onsite LPs must hold BLS or a more advanced life support certification.
- Updated copies must be obtained before expiration.

Acceptable Verifications – Life Support Certificates
Copies of life support certifications are acceptable and do not require primary source verification.

Software – Life Support Certificates
LPs submit information for all active life support certifications on the MD-App credentialing application.
- All active life support certifications are documented in the License/Credential tab:
  - Licensure Board: Name of life support entity
  - License Type: The type of life support
  - Limitations: Any license limitations

  - Comments: Comments regarding the license
  - Issued: Date the license was issued
  - Expired: Date the license expires
  - In Use: Determines whether the license is in use. Check for *In Use* for active licenses and uncheck for inactive licenses.
- If an LP does not renew an active life support certification, change the Type to **Inactive Life Support** and uncheck the **In Use** box.
- See Subsection 3 for instructions on how to attach a manual verification. See Subsection 2 for information about duplicate entries and shared MD-Staff tabs.

14. IMMUNIZATIONS

Verification Element – Immunizations

The collection of immunizations is not required as part of the credentialing process.

15. CURRENT LIABILITY INSURANCE

Verification Element – Current Liability Insurance

The FTCA provides malpractice coverage for federal employees, certain contractors, and volunteers, including ISDEAA contractors, thereby eliminating the need for private insurance when acting within the scope of their official duties. Questions about FTCA coverage should be directed to the HHS Office of the General Counsel.

Credentialing files must include proof of current malpractice insurance coverage or information that the LP is an IHS employee covered under the Federal Tort Claims Act (FTCA). Medical professional liability insurance for contractors is a condition for approving requested privileges. Employing contractors who do not have current, adequate coverage puts the agency at risk.

Standard Work Element – Current Liability Insurance

- Contractors not covered by the FTCA must provide acceptable verification of active liability insurance at initial appointment and before coverage expires.
- IHS employees are not required to maintain professional liability insurance.

Acceptable Verifications – Current Liability Insurance

- The following are acceptable verifications for current liability insurance:
  - Completed OMB-approved Malpractice Merge Verification Form from the malpractice carrier.
  - A copy of the certificate of insurance (COI) from the malpractice carrier or contracting agency.
  - A verification letter from the malpractice carrier.
- The COI or verification letter must include the LP's name, minimum coverage as required by the underlying contract (historically $1 million individual and $3 million aggregate), issued and expiration dates, and covered affiliations, if applicable.

- Verification of FTCA coverage is not required.

Software – Current Liability Insurance
LPs submit a complete list of all current, previous (within the last 5 years), and future liability insurance carriers on the MD-app credentialing application. The insurance carrier's name, policy number, coverage, and dates held are also reported.

- For employed (IHS) LPs, an FTCA entry is documented in the Insurance tab.
- Liability insurance information and verifications are documented in the Insurance tab:
  - 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 LP's primary insurance.
  - In Use: Whether or not the insurance is currently in use
- For active malpractice insurance subscriptions that become inactive, the *In Use* box will be unchecked.
- See Subsection 3 for instructions on how to complete an automated or manual verification. See Subsection 2 for information about duplicate entries, shared MD-Staff tabs, verification attempts, and unfavorable findings.

16. PROFESSIONAL LIABILITY CLAIMS, SUITS, AND/OR JUDGMENTS

Verification Element - Professional Liability Claims, Suits, and/or Judgments
Information on professional liability claims, suits, and judgments help assess an LP's malpractice history, identify risk patterns and gauge professional liability. These verifications help ensure that practitioners meet the high standards expected in healthcare settings, protecting patients and the integrity of the IHS facility.

Standard Work Element – Professional Liability Claims, Suits, and/or Judgments

- At the initial appointment and reappointment, documents listed as acceptable verifications are reviewed for any medical malpractice history and ascertain the background, status, and nature of any malpractice cases associated with the LP.

Acceptable Verifications – Professional Liability Claims, Suits, and/or Judgments

- NPDB query report.
- Professional practice question answers and explanations on the MD-App credentialing application.
- Malpractice Claims section on the MD-App credentialing application.

- Responses on affiliation verifications or peer references regarding claims, suits, and/or judgments are reviewed. An explanation will accompany any information regarding a claim, lawsuit, and/or judgment.
- Additional documentation, such as court documents, provider statements, etc.

Software – Professional Liability Claims, Suits, and/or Judgments
The LP documents any current (open or pending) and previous lawsuits or complaints on the MD-App credentialing application.

  - The LP answers all professional practice questions regarding liability claims, suits, and/or judgments. Professional practice question answers are displayed on the MD-App application.
  - Lawsuits or complaints added in the Malpractice Claims section of the application are displayed in *Additional Items* > *Incidents/Claims*. Additional documents, such as court documents, are stored in the Files section.
  - Additional documentation, such as court documents, provider statements, etc. are viewed in the Files tab.
- See Subsection 2 for unfavorable findings.

17. SANCTIONS DISCLOSURE, CURRENT INVESTIGATIONS AND OTHER VERIFICATIONS

Verification Element – Sanctions Disclosure or Current Investigations
Sanctions disclosure and government database checks are essential to ensure LPs meet regulatory and ethical standards. Providers listed with sanctions or exclusions (e.g., revocation, probation, civil complaint) are subject to immediate review by the Credentialing Committee, CD, and Area CMO. These checks are performed across various databases.

- **Office of Inspector General (OIG)/List of Excluded Individuals and Entities (LEIE):** The OIG/LEIE provides monthly updates on practitioners barred from federal healthcare programs for fraud or misconduct. Checking the OIG/LEIE website ensure facilities do not employ individuals who could compromise patient safety or IHS compliance.
- **System for Award Management (SAM):** Formerly GSA/EPLS (General Services Administration/Excluded Parties List System), SAM tracks federal debarments, including OIG and state sanctions, and lists entities barred from receiving federal contracts or grants. Checking SAM confirms LP eligibility for federal healthcare programs and supports IHS compliance.
- **Federation of State Medical Boards (FSMB):** The FSMB is a comprehensive primary source for state licenses, disciplinary sanctions, closed residency programs, and affiliations. FSMB is a paid verification that is encouraged but not required; facilities may verify directly with state medical board instead.
- **Centers for Medicare & Medicaid Services** (**CMS) and State-Specific Opt-Out:** The NPDB's CQ 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 healthcare services provided to patients. MD-Staff directly queries the CMS Medicare Opt-out list, which the CMS maintains and updates monthly.

- **Ability to Perform (Health Status):** LPs health status is evaluated through attestation questions on the credentialing applications. As an important reminder, the LP completes the application and these questions only after an employment offer or selection as part of a contract. LPs must confirm their ability to practice their profession safely and to make any reasonable accommodation requests.
- **National Provider Identifier (NPI):** The NPI is a unique number assigned to LPs by CMS through the National Plan and Provider Enumeration System (NPPES.) Required under the Health Insurance Portability and Accountability Act (HIPAA) is necessary for billing and reimbursement of patient care services.
- **Internet Search:** Internet searches can reveal information beyond traditional credentialing sources - such as news articles, social media profiles, and public records -helping identify potential conduct issues and support thorough, informed credentialing decisions.

Standard Work Element – Sanctions Disclosure or Current Investigations

- **OIG/LEIE:** Verified for each LP at the initial appointment. Enrollment in the NPDB CQ meets this requirement for reappointment.
- **SAM/GSA:** Verified for each LP at initial and reappointment and at any other times identified by the facility's accrediting/certifying body or Area/Facility policy.
- **FSMB:** See Item (6) Licensure above.
- **CMS State-Specific Opt-Out:** Verified for each LP at the initial and reappointment. Enrollment in the NPDB CQ meets this requirement.
- **Ability to Perform (Health Status):** Confirm that the LP has completed the attestation questions on the credentialing applications.
- **NPI:** Verified for each LP at initial appointment.
- **Internet Search:** Complete internet search at the pre-screen and initial appointment. Check for any red flags, such as reports of malpractice, criminal activity, professional or personal misconduct, or other relevant issues. Add the internet search information in the Verification Log. See the instructions below.

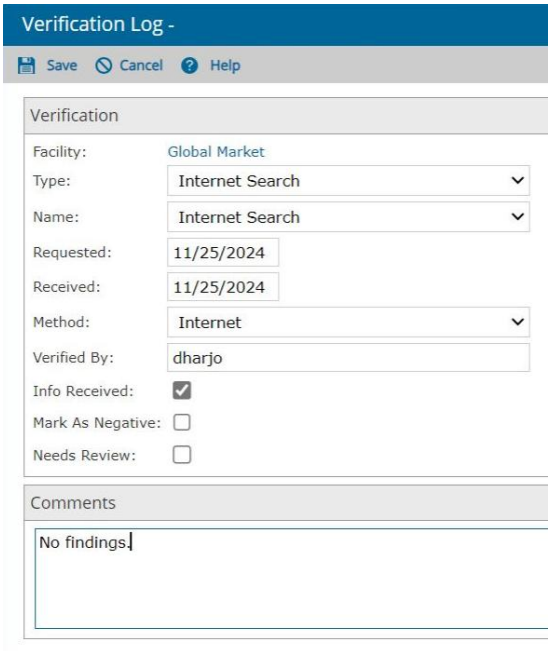
Acceptable Verifications – Sanctions Disclosure or Current Investigations

- **OIG/LEIE:** OIG report or NPDB query report.
- **SAM/GSA:** EPLS (SAM/GSA) report.
- **FSMB:** See Item (6) Licensure above.
- **CMS State-Specific Opt-Out:** The NPDB or the Medicare opt-out verifications can be completed electronically in MD-Staff.
- **Ability to Perform (Health Status):** Completed attestation questions on the credentialing application.
- **NPI:** NPI report.
- **Internet Search:** While not considered a verification and may not be a reliable source, internet checks provide additional information to analyze and corroborate the applicant's information.

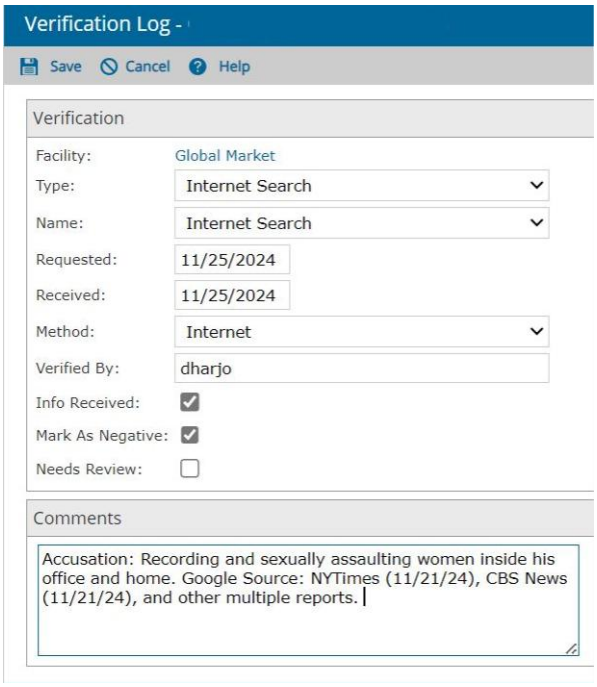
Software – Sanctions Disclosure or Current Investigations

- **OIG/LEIE, SAM/GSA, CMS State-Specific Opt-Out, NPDB Query Report, and NPI:** These verifications are stored in the Verifications Log. When run through MD-Staff, the verification details are automatically added to the Verification Log:
  - When importing an MD-App application, selecting the *Verify All* checkbox generates the report and adds it to the Verification tab.
  - Verification section in MD-Staff.
  - *Verify All* function found under *Tools*.

  To run a report in MD-Staff, the following fields must be filled in the Demographic tab:
  - OIG/LEIE: First Name, Last Name, Social Security Number, Birth Date, and any aliases the LP may have. MD-Staff downloads the OIG database every Monday at 7:30 PM PDT from OIG Exclusions. Please note that, on average, OIG only updates this database once a month.
  - SAM/GSA: To run a report in MD-Staff, NPI must be filled in the Demographic tab. However, note that the comments in the Verification Log will still say "SSN".
  - CMS State-Specific Opt-Out: To run a report in MD-Staff, the NPI field must be filled in the Demographic tab.
  - NPI: To run a report in MD-Staff, the NPI field in the Demographic tab must be populated.
- **Internet Search:** Internet search information is documented in the Verification Log. The search will be documented, even if no negative or concerning findings are discovered:
  - Type and Name: “Internet Search,”
  - Requested and Received dates: The date the internet search was completed.
  - Method: Internet:
  - Verified by: The individual that completed the internet search.
  - Info Received: Check this box
  - Mark As Negative: Only check this box if negative findings were discovered
  - If there were no findings, include “No findings” in the Comments.



- If concerning findings arise from the internet search, summarize them in the *Comments* section with sources and dates. Save screenshots in the LP's Verification Log and promptly notify the credentialing committee and/or the clinical director.



- **State-Specific Sanctions Verifications in MD-Staff:** MD-Staff allows for verification of state-specific sanctions.
  - To manage state sanction verifications, go to Setup > Web Services > Sanction Settings. IHS recommends activating all Sanctions sites. States marked *False* under the *Enable* column are inactive – select and click Activate to enable. To run verifications, go to Verification > Sanctions and choose Verify by Name, Verify by Filter (to choose and verify multiple providers), or Verify All (for all active providers).

VERIFICATION TYPES

Acceptable verification types include:

- Primary Source Verifications: 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 DES can vary, depending on the accrediting organization. For example, The Joint Commission lists the AMA Physician Profile as a DES for verifying medical education.
- Secondary Source Verifications: Verifications that do not originate from the issuing entity/organization or a designated equivalent source. These should be used rarely. Secondary

source verification is conducted by a reliable secondary source, such as another hospital that has documented primary source verification of the credential.

Credentials must be verified through primary or designated equivalent sources. Verifications submitted directly by the applicant are not acceptable. When primary or designated equivalent verification is unobtainable—such as when an institution or program has closed—secondary source verification may be used only in rare cases and in accordance with facility and accrediting body standards. Copies of diplomas, licenses, or registrations are not acceptable substitutes. If primary verification cannot be obtained, the applicant's recent affiliations should be contacted to determine how they verified the credential. Request to obtain a copy of that verification.

Paid verifications, including those conducted through AMA, AOA, NSC, or ECFMG, do not permit sharing per their terms of use unless the area is set up as a formalized centralized credentialing office.

GENERAL ADMINISTRATIVE VERIFICATION REQUIREMENTS

Credentialing verifications ensure applicants meet required standards of licensure, competency, character, education, training, and judgment for their roles and requested clinical privileges. This section outlines the administrative requirements and processes for credentialing Licensed Practitioners (LPs) seeking clinical privileges.

- Verification Completion Date: The date the verification was completed must be documented. If the verification does not display the date, the document is electronically signed and dated to record the verification completion date.
- Discrepancies:
  - The MSP must compare the CV/resume with the application and verification documents, identifying and resolving any discrepancies. The practitioner may correct any information through a written, signed response, verified when possible. If discrepancies remain, the practitioner must contact the verifying entity to resolve them.
  - The burden of proof is on the applicant to provide all necessary verifiable information to support their application and to conduct required verifications.
  - Ensure all application and verification data in the software are accurate, including "From" and "To" dates in the Education/Training, Hospital, and Other References sections.
- Shared MD-Staff Tabs:
  - The Hospitals, Education/Training, Other References, Peer References, Licenses/Credentials, Board Certifications, and Insurance tabs in MD-Staff are shared. Information entered in these MD-Staff tabs is visible to all IHS facilities listed in the LP's Appointment tab.
  - Changes to these entries will update the information for all facilities listed in the LP's Appointment tab. MD-Staff users should account for this when editing shared tabs for LPs with multiple appointments.
- Duplicate entries:
  - If duplicate entries are found in any tab, identify the correct entry against source verification or documentation, then coordinate with affiliated sites to remove duplicates.

  - When verifications are added, they are automatically recorded in the Verification Log. Deleting an entry does not remove its associated verification from the log.
- Purchase Card Holders:
  - MD-Staff users with IHS-issued individual purchase cards may use them within MD-Staff, in compliance with the IHS Credentialing and Program Government Purchase Card procedures.
- Verification Attempts:
  - At least three verification attempts must be made and documented in the Notes section, including contact details, dates, methods, and comments. If necessary, confirm contact information with the applicant and request their assistance in obtaining the verification. For non-responsive entities may indicate a potential red flag.
- Expirable Alarms:
  - Expirable credentials should have automated scheduled messages to alert LPs before credentials expire.
- Software Disruptions:
  During credentialing software outages, service units or areas must continue primary source verifications outside the system. Once restored, all information and verifications must be entered and uploaded to MD-Staff.

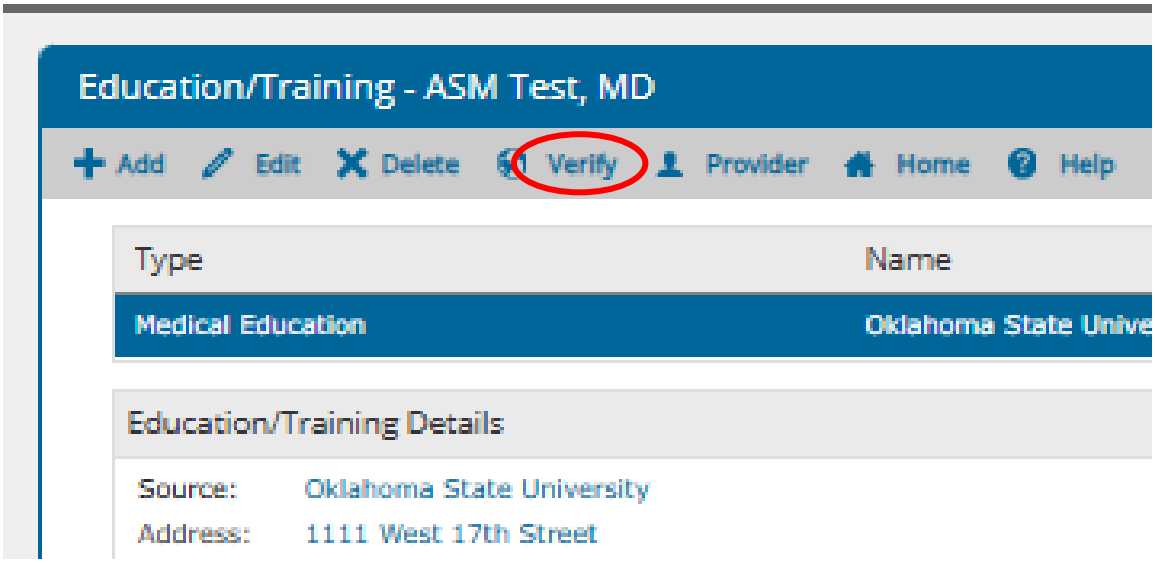
- Unfavorable Findings:
  - Unfavorable findings identified during credentialing must be reported to appropriate medical staff and governing body leadership. Per IHM 3-1, applicants must disclose any prior or pending denials, restrictions, or resignations of privileges; licensure or membership actions; drug use; or convictions. These disclosures are verified through application questions, affiliation checks, peer references, and coordination with HR, PSR, and contracting. Negative verification comments must be documented with explanatory context, and the clinical director or designee should follow up as needed to clarify concerns.
- Checklists:
  - MD-Staff supports customizable electronic checklists and automated Aiva cycles to ensure accurate and complete credentialing verifications and documentation. All facilities are required to utilize checklists as part of the credentialing process.
- MHT Capture:
  - MHT capture may be used for online credential verifications by saving the webpage as an MHT file. Note: MHT files cannot be viewed in Virtual Committee.

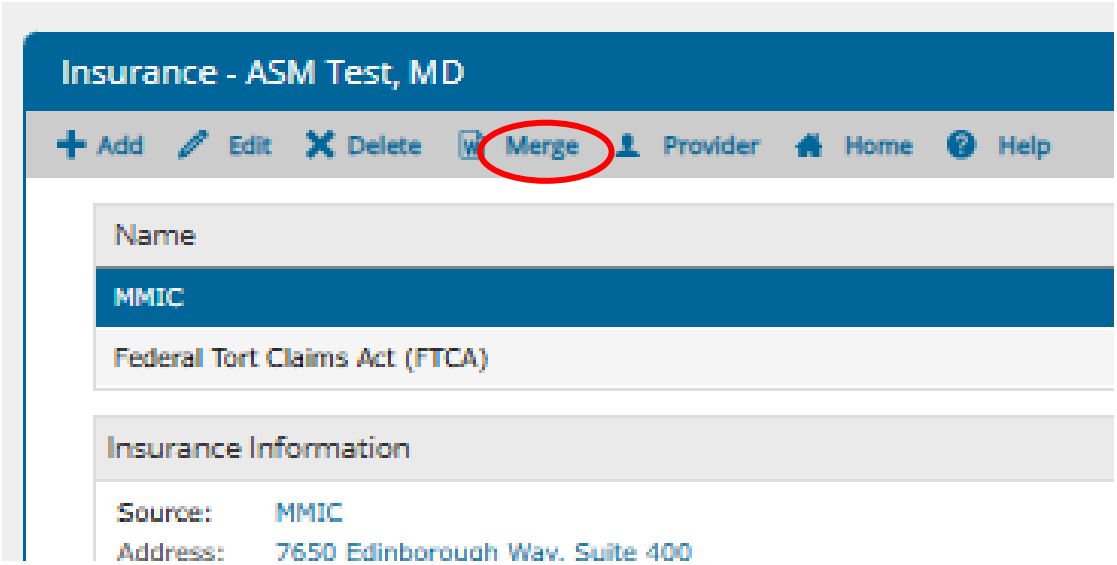
AUTOMATED AND MANUAL VERIFICATION DOCUMENTATION PROCESS

All verifications, automated or manual, must be attached to the corresponding MD-Staff entry. Automated verifications use MD-Staff's electronic features and should be used whenever possible for efficiency. Manual verifications rely on primary or designated equivalent sources outside MD-Staff must still be uploaded to MD-Staff. Automation setup may be required; users needing assistance should contact the ASM.

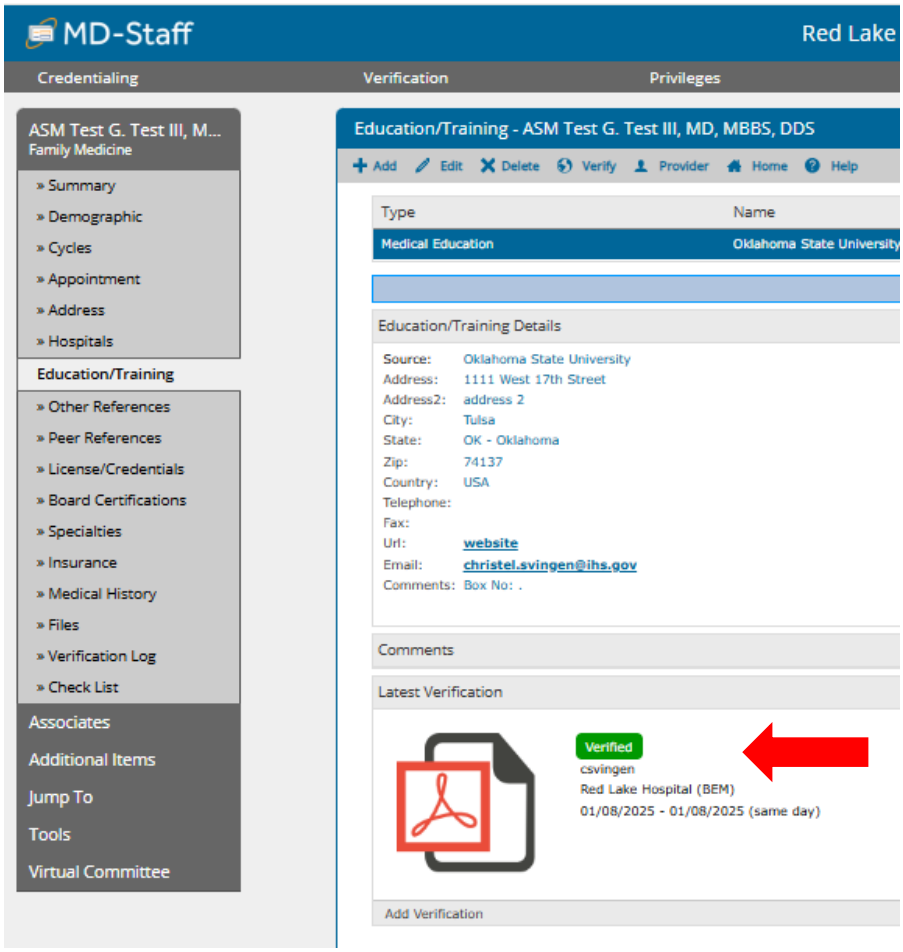
Automated MD-Staff Verification Functions:

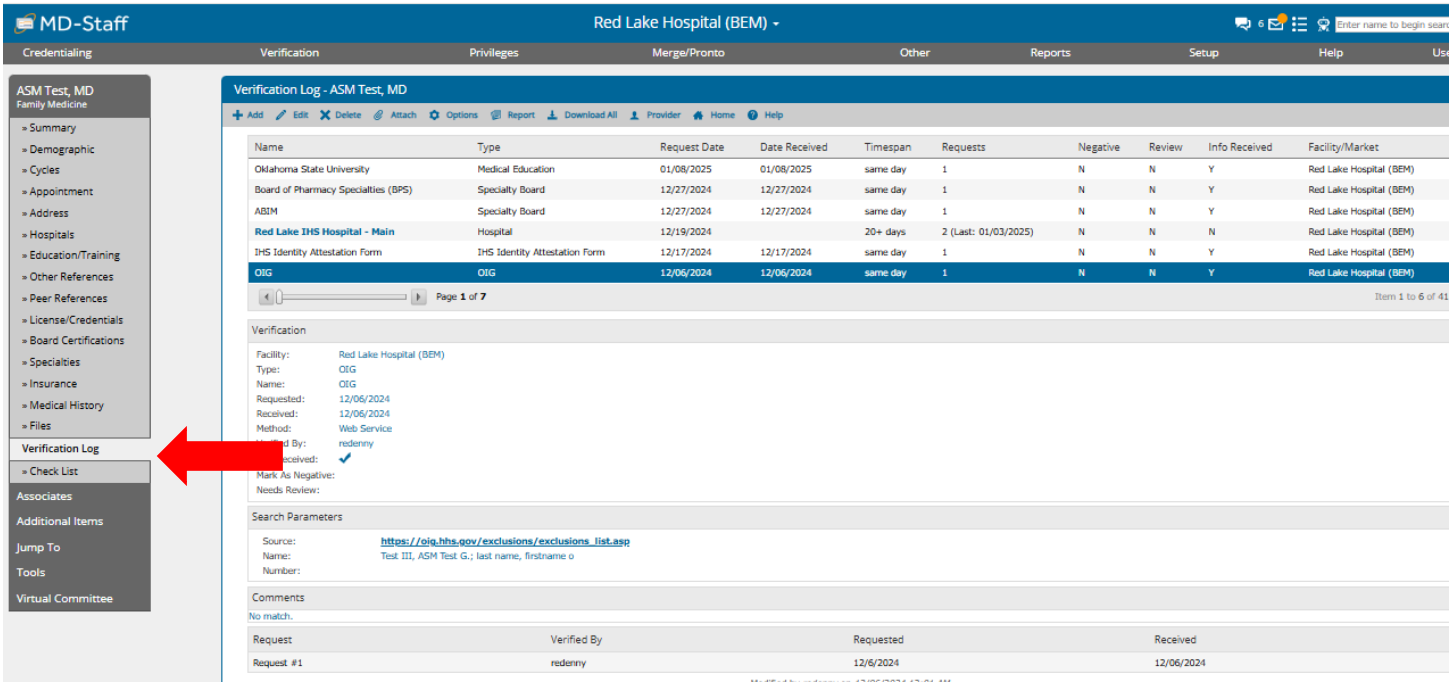
- Verify and Merge Functions in MD-Staff Tabs: Use the *Verify* or *Merge* functions within an entry to run automated verifications in the Hospitals, Education/Training, Other References, Peer References, License/Credentials, Board Certifications, and Insurance tabs.





Once complete, the verification document and associated information will appear in the *Latest Verification* section of the entry and automatically be added to the Verification Log. This is important because credentialing compliance data for reports are extracted from the Verification Log. To complete a verification using automated functions, use the *Verify* or *Merge* functions within the entry.

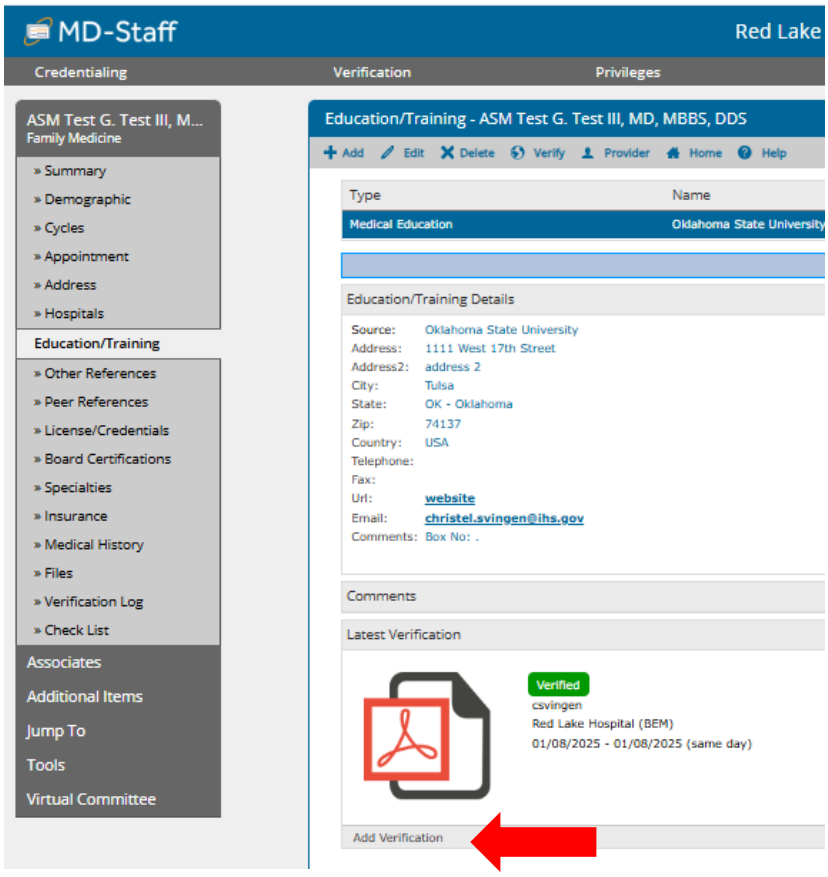

MD-Staff
Red Lake
Credentialing
Verification
Privileges
ASM Test G. Test III, M...
Family Medicine
» Summary
» Demographic
» Cycles
» Appointment
» Address
» Hospitals
Education/Training
» Other References
» Peer References
» License/Credentials
» Board Certifications
» Specialties
» Insurance
» Medical History
» Files
» Verification Log
» Check List
Associates
Additional Items
Jump To
Tools
Virtual Committee
Education/Training - ASM Test G. Test III, MD, MBBS, DDS
Add
Edit
Delete
Verify
Provider
Home
Help
Type
Name
Medical Education
Oklahoma State University
Education/Training Details
Source: Oklahoma State University
Address: 1111 West 17th Street
Address2: address 2
City: Tulsa
State: OK - Oklahoma
Zip: 74137
Country: USA
Telephone:
Fax:
Url: website
Email: christel.svingen@ihs.gov
Comments: Box No: .
Comments
Latest Verification
Verified
csvingen
Red Lake Hospital (BEM)
01/08/2025 - 01/08/2025 (same day)
Add Verification


MD-Staff
Red Lake Hospital (BEM)
Credentialing
Verification
Privileges
Merge/Pronto
Other
Reports
Setup
Help
ASM Test, MD
Family Medicine
» Summary
» Demographic
» Cycles
» Appointment
» Address
» Hospitals
» Education/Training
» Other References
» Peer References
» License/Credentials
» Board Certifications
» Specialties
» Insurance
» Medical History
» Files
Verification Log
» Check List
Associates
Additional Items
Jump To
Tools
Virtual Committee
Verification Log - ASM Test, MD
Add
Edit
Delete
Attach
Options
Report
Download All
Provider
Home
Help
Name
Type
Request Date
Date Received
Timespan
Requests
Negative
Review
Info Received
Facility/Market
Oklahoma State University
Medical Education
01/08/2025
01/08/2025
same day
1
N
N
Y
Red Lake Hospital (BEM)
Board of Pharmacy Specialties (BPS)
Specialty Board
12/27/2024
12/27/2024
same day
1
N
N
Y
Red Lake Hospital (BEM)
ABIM
Specialty Board
12/27/2024
12/27/2024
same day
1
N
N
Y
Red Lake Hospital (BEM)
Red Lake IHS Hospital - Main
Hospital
12/19/2024
20+ days
2 (Last: 01/03/2025)
N
N
N
Red Lake Hospital (BEM)
IHS Identity Attestation Form
IHS Identity Attestation Form
12/17/2024
12/17/2024
same day
1
N
N
Y
Red Lake Hospital (BEM)
OIG
OIG
12/06/2024
12/06/2024
same day
1
N
N
Y
Red Lake Hospital (BEM)
Page 1 of 7
Item 1 to 6 of 41
Verification
Facility: Red Lake Hospital (BEM)
Type: OIG
Name: OIG
Requested: 12/06/2024
Received: 12/06/2024
Method: Web Service
Verified By: redenny
Mark As Negative:
Needs Review:
Search Parameters
Source: https://oig.hhs.gov/exclusions/exclusions_list.asp
Name: Test III, ASM Test G.; last name, firstname o
Number:
Comments
No match.
Request
Verified By
Requested
Received
Request #1
redenny
12/6/2024
12/06/2024

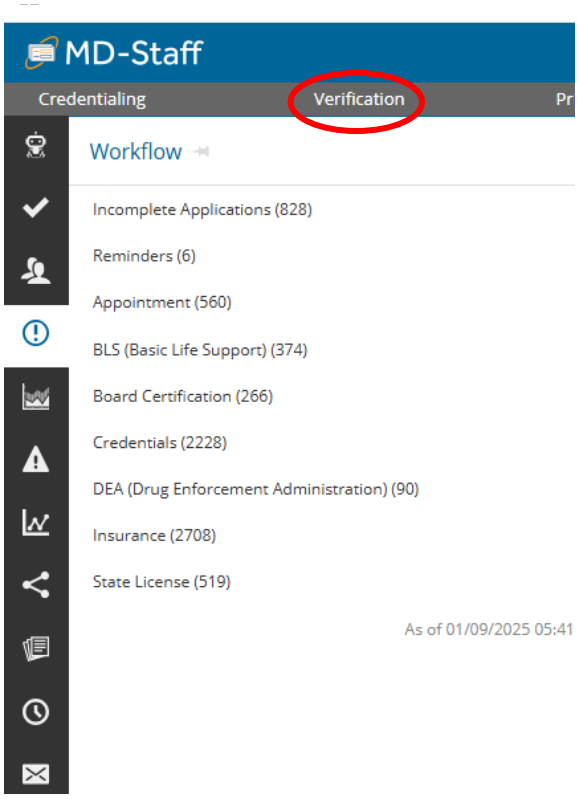
Add Verification Function in MD-Staff Tabs:

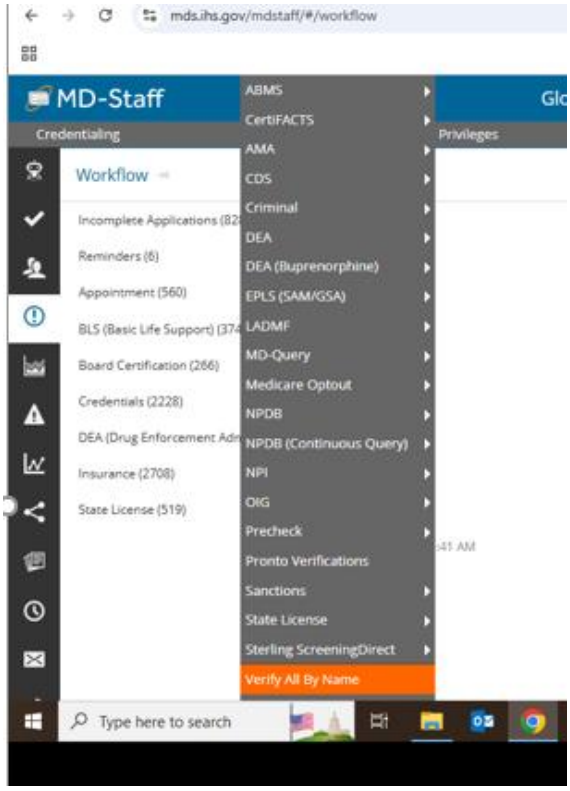
If MD-Staff automation is unavailable for a verification, it must be completed manually and attached to the appropriate provider profile tab (e.g., Hospitals, Education/Training, References, Licenses, Certifications, Insurance). Manually completed verifications must be added using the Add Verification function, which records them in both the entry's Latest Verification section and the Verification Log. This is important because credentialing compliance data are extracted from the Verification Log for reports. Automated and manual verifications can be edited from the Verification Log tab. The Add Verification process is as follows:

1. Click on the entry where the verification needs to be added.
2. Click *Add Verification* at the bottom of the screen:
    a. Date Requested: The date the verification was requested.
    b. Method: How the verification was received
    c. Date Received: The date the verification was received.
    d. Negative: If any information on the verification is negative, click on the box next to this field.
    e. Comments: Add notes, reminders, comments, or additional information.
3. Click *Save*
4. 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. If there is no file to attach, click *Close*.

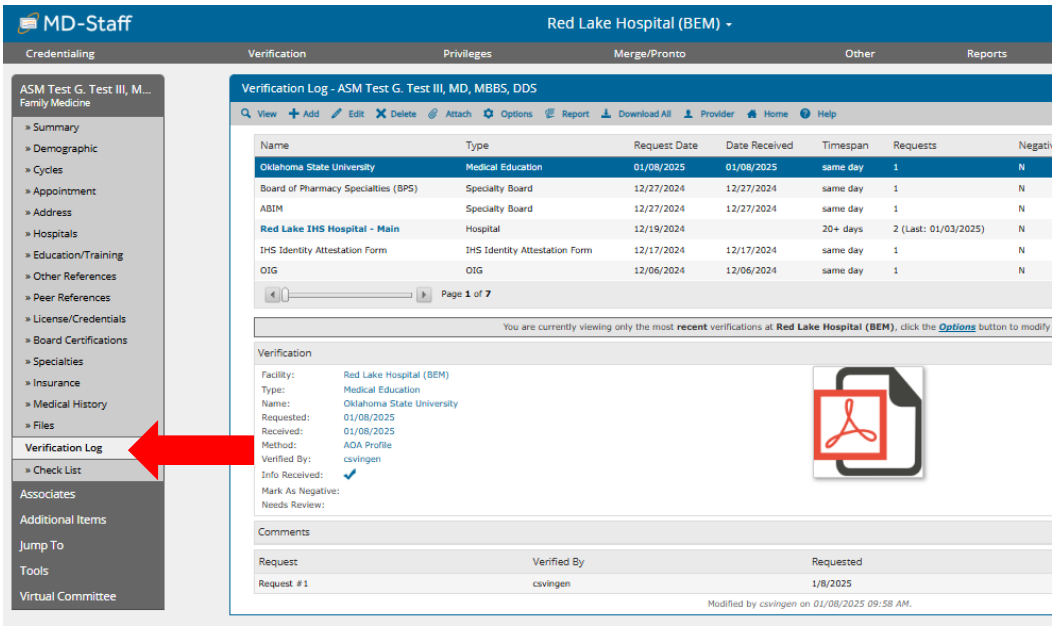


- <u>Verification Section in MD-Staff:</u> The Verification section houses options for multiple web-based automated verifications, including OIG, NPI, SAM/GSA, Medicare Optout, etc. privileged



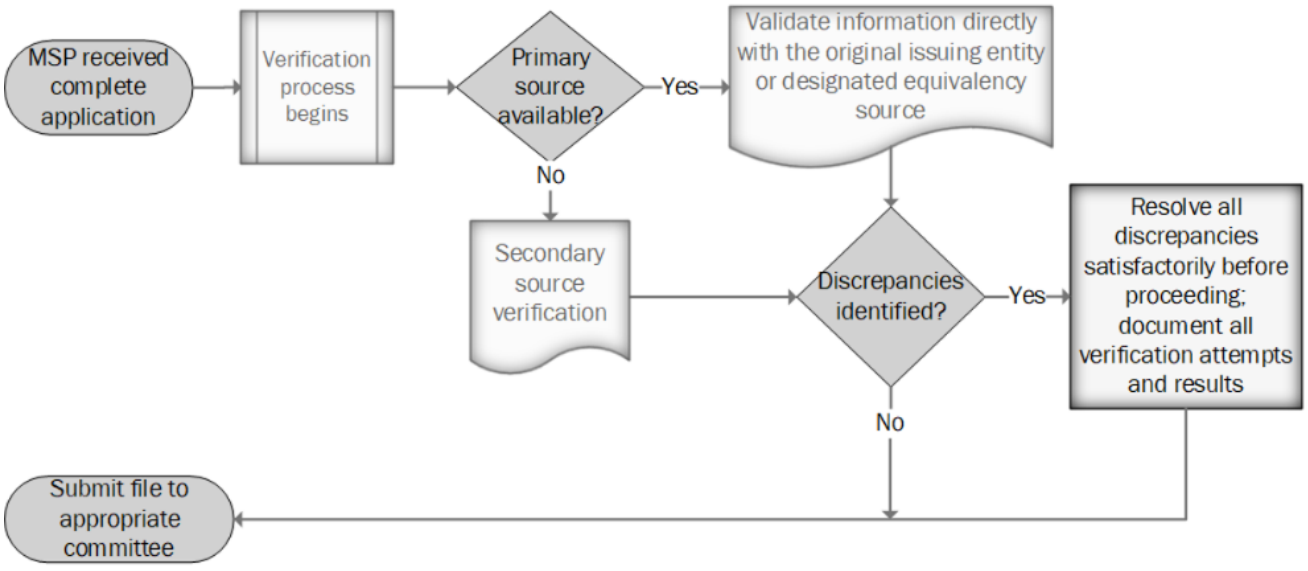


There are multiple ways to run automated verifications, including through the Verification section, upon importing an MD-App application or using the *Verify All* function found under *Tools*. MD-Staff automatically adds the verification information to the Verification Log when an automated verification is processed. This is important because credentialing compliance data for reports are extracted from the Verification Log. The verification may also be edited in the Verification Log by selecting the verification entry and clicking on *Edit*.



VERIFICATION PROCESS

The process map outlines the verification process:



Credentialing High Risk Findings and Management

All licensed practitioner (LP) applications, forms, and tools are reviewed for high-risk findings. If such findings are identified, the Clinical Director (CD) is notified, and the file must be submitted to the Agency Clinical Credentials Committee (ACCC) for endorsement consideration before review by the Governing Body (GB). An endorsement determination request to the ACCC may proceed at any point during the credentialing process, as determined by clinical leadership. The GB or its delegated committee that holds final authority to grant, renew, or deny privileges. The IHS Headquarters ACCC reviews all requests for endorsement determinations, which must be received prior to final GB approval and before the LP may provide patient care.

Initial ACCC reviews are not professional review actions and are not reportable to the National Practitioner Data Bank. High-risk findings may involve any aspect of an LP's credentials, including but not limited to, education, training, licensure, experience, professionalism, or conduct.

The professional practice questions in the application serve to identify any potential high-risk indicators or findings. Clinical leadership must review the rationale for all affirmative ("Yes") responses. All affirmative ("Yes") responses that align with the identified high-risk findings below must receive an endorsement determination from the ACCC:

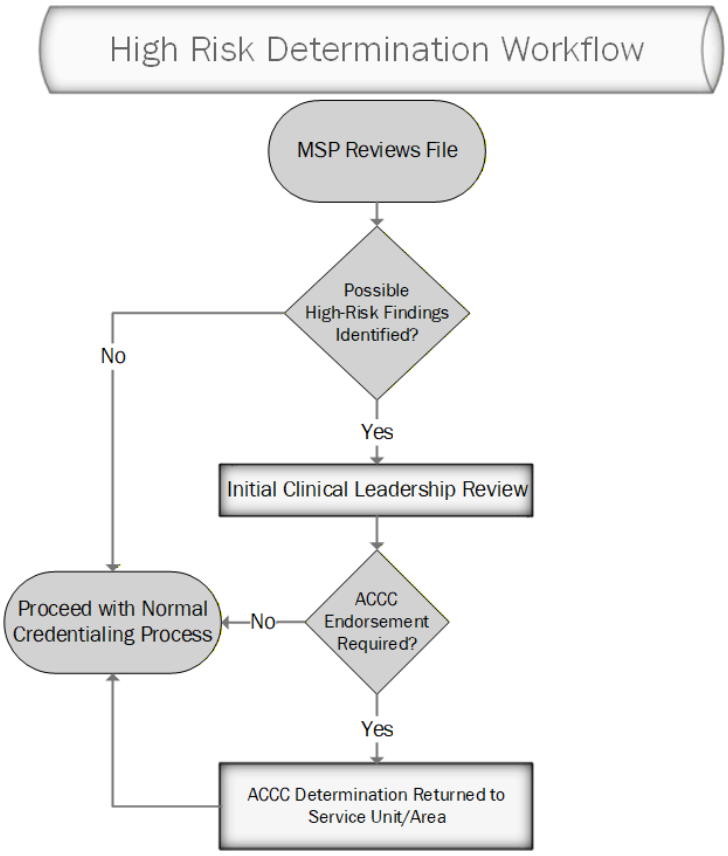
- Suspension, restriction, revocation, denial, probation, or involuntary relinquishment of any clinical professional license or registration held by the licensed practitioner
- Suspension, restriction, revocation, or denial of employment, medical staff membership, or clinical privileges at any place of employment, including hospitals, clinics, or other healthcare settings
- Subject of a civil, criminal, or administrative action regarding sexual misconduct, child abuse, domestic violence, elder abuse, intimate partner violence, or other violent crimes;
- Any arrest, charge, conviction, or sentence for the following crimes:
  - Driving under the influence (DUI) or while impaired or intoxicated
  - Sexual misconduct
  - Illegal drugs forbidden by federal law
- Not Board Certified or Board Eligible or historically exempt from the Board Certification/Eligible Requirement

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

QUESTION #	PROFESSIONAL PRACTICE QUESTION
1	Has your license to practice in any jurisdiction ever 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?
3	Has your license ever been voluntarily or involuntarily withdrawn?
4	Have any disciplinary actions or investigations ever been initiated against you by any state licensure board?
5	Have you ever been reprimanded or fined by any local, state, or federal agency that licenses providers?
6	Have you ever been subject to proceedings by any government agency, licensing board, hospital, or professional association to revoke, suspend, or limit your professional license, registration, or permit?
7	Have you ever been the subject of a complaint or investigation by a state or federal licensing agency?
8	Have you ever been notified that you were being investigated by a healthcare organization, licensing board, or professional association?
9	Have you ever been cautioned, reprimanded, or disciplined by an institution, employer, or professional society?
10	Have your employment or clinical privileges ever been denied, suspended, revoked, restricted, or voluntarily/involuntarily relinquished?
11	Have you ever withdrawn or terminated clinical privileges before a governing board's final decision?
12	Have you ever been excluded, suspended, or voluntarily withdrawn from participation in Medicare, Medicaid, TRICARE, or other government programs?
13	Have any third-party payers or agencies brought charges against you for inappropriate fees or quality-of-care issues?
14	Has any information about you (e.g., malpractice or disciplinary actions) been reported to the National Practitioner Data Bank or other oversight authorities?
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?
17	Have you ever had a professional negligence claim filed against you?
18	Have liability claims or settlements been made against an entity in connection with your professional activities?
19	Have you ever had professional liability coverage denied, refused, or canceled?
20	Have you ever withdrawn from, or been 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 during training?
22	Have you ever been the subject of a civil, criminal, or administrative action (or investigation) involving sexual misconduct, abuse, or other violent crimes?
23	Are you aware of any impairment that could limit your ability to perform clinical duties?
24	Are you currently engaged in the illegal use of any substances?
25	Do you have any reason to believe you could pose a risk to patient safety or well-being?

26	Has it been more than 12 months since you last provided patient care?
27	Have you ever been arrested, charged, or convicted of a felony or misdemeanor (other than minor traffic violations), including expunged or withheld judgments?
28	Have you ever been the subject of disciplinary action in any educational or training program?



Risk Management

Clinical risk management, which underpins the delivery of quality and safe patient care, is a priority for the Indian Health Service (IHS). Clinical administrators and licensed practitioners are encouraged to review and become familiar with the IHS Risk Management Manual, which outlines policies and procedures related to medical care risk management and medical malpractice tort claims within the federal system.

Implementing effective risk management techniques enhances the quality of patient care while proactively reducing the likelihood that adverse events lead to medical malpractice claims. Equally important is the ongoing analysis and review of tort claims to identify and address underlying system issues that require corrective action.

Ultimately, the goal of healthcare risk management is to minimize the risk of harm to patients, reduce liability exposure for healthcare providers, and prevent financial loss to the agency, thereby fostering a culture of safety, accountability, and continuous improvement.

Shared Credentialing 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. These requests must have final approval by the IHS Director. Credentialing records are protected by U.S. Code 25 §1675. Applicant/employee health records, including those received during the credentialing process, are protected under 42 U.S.C. § 12112(d) and 29 C.F.R. § 1630.14. 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 collecting information, the categories of individuals whose records are collected, and the categories of records in the system that do not require a signed release of information. As one agency using one credentialing software, IHS may share some credentialing and privileging records as part of routine use. However, 25 U.S.C. § 1675 places additional limits on disclosure, even within IHS.

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 for the purpose of enabling 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 through a current application and a current signed IHS Conditions of Application and Release; 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 primary source verifications can **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, the time between when the application is received and when it's

reviewed. This excludes unpaid historical verifications where the information does not change, such as residency, education, and affiliations directly verified with the program or entity. Additionally, peer references can be shared if the current OMB-approved peer reference form is used and meets the peer reference requirements defined in this SOP. Peer references 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.

Sharing credentialing records with licensed practitioners:
Only records and documents submitted by the LP may be shared with the LP. LPs may not have access to verifications, queries, or documents completed, processed, verified, or received for credentialing purposes. For example, if the LP submits a copy of their CV, diploma, or license, these documents can be provided to the LP. However, we cannot provide LPs a copy of the affiliation verifications, peer references, education verification, etc.

Sharing NPDB query reports with IHS departments:
Credentialing records may be shared with staff in other departments within the IHS when the information is required for the staff member to perform their official duties. An NPDB (National Practitioner Data Bank) query report may be shared with staff in another IHS departments when involved parties are participating in the same decision-making process — that is, one business decision for one practitioner. Examples include sharing the NPDB query report with Human Resources for Title 38 market pay determinations or with the Business Office for provider enrollment purposes.

Sharing credentialing records with IHS facilities:
The table below lists documents and verifications that are shareable and not shareable within IHS facilities, where and how the records are filed in the software, and whether the record can be shared with the practitioner. The facility credentialing and privileging the LP do not have 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 LP's record for facilities that wish to use them. Either method may be used, but a complete credentialing file and supporting verifications are required.

Documentation Verification	Shareable within IHS?	Files Section Notation	Shareable to LP	Verification Location
Board Certification Certificate	Yes	Global	Yes	Files
Board Certification Verification	No	Facility Specific	No	Board Certification tab
Certificate of Insurance (COI)	Yes	Global	Yes	Insurance tab
Continuing Medical Education Certificates and Summaries	Yes	Global	Yes	Files
Court Records	Yes	Global	Yes	Files

DEA, DPS, and CDS Verifications	No	Facility Specific	No	License/Credentials tab
DEA, DPS, CDS Certificates	Yes	Global	Yes	Files
ECFMG Certificate	Yes	Global	Yes	Files
ECFMG Validation Verification	No	Facility Specific	No	License/Credentials tab
Exit Clinical Performance Summary IHM 3-1.3 (E)	Yes	Global	No	Files
GSA Exclusion	No	Facility Specific	No	Verification Log
IHS Conditions of Application and Release	Yes, if the provider signed the form in the last 12 months. If the provider signed the form more than 12 months ago, a new one needs to be collected.	Global	Yes	Files Section
Immunization Records	Yes	Global	Yes	Files
Initial Application	No	Facility Specific	Yes	Files
Internship, Residency, and Fellowship Verification	Maybe - Verifications directly from the school may be shared. The following organizations do not permit sharing of their profiles or verifications: AMA and AOA.	Global - If provided by the Program	No	Education/Training tab
Life Support Certificates	Yes	Global	Yes	License/Credentials tab
Malpractice History Verifications	Yes	Global	No	
Medical Degree Verifications	Maybe - Verifications directly from the school may be shared. The following organizations do not permit sharing of their profiles or verifications: AMA, AOA, ECFMG, and NSC	Global - If provided by the school or program	No	Education/Training tab
Medical Diploma, Internship, Residency and Fellowship Certificates	Yes	Global	Yes	Files

Medicare Opt-Out	No	Facility Specific	No	Verification Log
NPDB Query	No	Facility Specific	No	Verification Log
NPI	No	Facility Specific	No	Verification Log
OIG Exclusions Database	No	Facility Specific	No	Verification Log
Peer Reference	Maybe – These verifications may be shared if peer reference is current (signature is within two years of presentation to the GB)	Global, if current	No	Verification Log
Practice History-Affiliations, Work History, and Military Verifications	Maybe – These verifications may be shared if the time the LP practiced has passed when the verification was processed, there is no additional time to verify, and no new information would be gained from reverifying. Another verification must be obtained if the LP practice is still open at the appointment.	Global if affiliation time has ended otherwise facility specific	No	Hospitals tab (any entity where the LP was credentialed and privileged) Other References tab (all other work history)
Procedure Logs	Yes	Global	No	Files
Proof of Identity	No	Facility Specific	No	Verification Log
State Licenses Certificates	Yes	Global	Yes	Files
State License Verifications	No	Facility Specific	No	License/Credentials tab

Below is a table that illustrates which 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 LPs.
- Shared (Global) - all facilities that are affiliated with that LP can view.

Category	Facility Specific	Shared (Global)
Summary	Display Only	Display Only
Demographic		✅
Cycles	✅	
Appointment	✅	
Address		✅

Hospitals		☑
Education/Training		☑
Other References		☑
Peer References		☑
Licenses/Credentials		☑
Board Certifications		☑
Specialties	☑	
Insurance		☑
Medical History		☑
Files	☑ (unless marked Global)	☑ (if marked Global)
Verification Log	☑	
Checklists	☑	

Associates

Item	Facility Specific	Shared (Global)
Supervisors	☑	
Coverage	☑	
Referrals	☑	

Additional Items

Item	Facility Specific	Shared (Global)
Dues	☑	
Other Events	☑	
Incidents/Claims	☑	
Aliases		☑
Employment	☑	
Leadership	☑	
Passports/Visas		☑
Medical Societies		☑
Notes	☑	
Verification Enrollment	☑	

Jump To

Item	Facility Specific	Shared (Global)
View Privileges	☑	
Record Privileges	☑	
Proctor	☑	
Enrollment	☑	
Mail Log	☑	

Privileging Process

Privileges define the specific procedures and patient care services a Licensed Practitioner (LP) may perform at a facility. The process of evaluating and approving an LP to perform clinical duties is known as privileging.

Privileges are practitioner- and facility-specific, based on an individual's credentials and competency, as well as the facility's capability to support those services. Before an LP may practice, the facility must review the practitioner's credentials to determine the practitioner's areas of expertise and procedural competencies, which are outlined in privilege forms. , and the governing body (GB) must formally grant privileges. Administrative duties do not require clinical privileges.

All LPs providing patient care in IHS facilities must maintain current, active, and unrestricted licensure, registration, certification, credentials, and competence. They must also demonstrate proficiency in their requested privileges in accordance with applicable laws, accreditation standards, IHM 3-1, this SOP Manual, privilege criteria, and employment conditions.

Under the Medicare Conditions of Participation (CoP) for hospitals, the GB must ensure that the medical staff, through its bylaws, defines criteria for evaluating and determining clinical privileges. Criteria should include individual character, competence, training, experience, and judgment consistent with licensure. The privileging process must be applied uniformly and objectively to all applicants. IHS Areas and Service Units may adopt more stringent—though not less stringent—credentialing and verification procedures than those specified in this SOP and IHM 3-1 Policy.

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

Low/No Volume Practitioners
Credentialing and privileging for low/no volume providers shall be subject to rigorous review and written standards established by the facility Governing Board, upon the recommendation of the Medical Executive Committee. Appointment and core privileges may be granted to providers within their area/specialty of training when there is evidence of ongoing competency assessment such as maintenance of certification (MOC) or equivalent. Privileges for invasive procedures and special procedures shall be subject to reasonable minimum volume thresholds and focused professional practice evaluation (FPPE), including proctoring as indicated, to ensure patient safety and quality of care.

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 privileging criteria. However, if the credentialing process is started for an application from a practitioner found not to meet the facility's requirements, the clinical director will be consulted regarding discontinuing the application because the applicant doesn't meet the privileging criteria. If the application is discontinued, the LP would be informed that he or she does not meet eligibility requirements, and the application process would be 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 an 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 the required education level, formal training requirements, and current experience.

Types of Privileging

Privileges define the specific clinical procedures and patient care services a practitioner is authorized to perform. They reflect the practitioner's expertise in particular areas. The process of evaluating and approving a practitioner's eligibility to perform specific clinical activities is called privileging.

Itemized Privilege List

Itemized privilege forms list every procedure or service a practitioner may perform within a specialty. As new procedures emerge, maintaining these detailed lists becomes costly and administratively burdensome, and infrequent updates can introduce additional risk. For these reasons, the agency's preferred privileging method is core privileging.

Core Privileging

Core privileges encompass the essential procedures and services that a practitioner within a specialty or subspecialty is expected to perform. These privileges are based on the education, training, experience, and demonstrated competencies typically acquired through ACGME- or AOA-approved residency programs, meaning most graduates have documented proficiency in these areas. The Joint Commission and the Centers for Medicare & Medicaid Services (CMS) recognize core privileging as a best practice in the industry. Core privileging promotes standardization across the credentialing and privileging process, streamlines professional practice evaluations, ensures alignment with national training and competency standards, and reduces the risk of errors or omissions. Procedures or services that are advanced, uncommon, or outside the defined scope of core privileges are designated as special privileges or procedures. These are delineated separately and require additional verification of specialized training, experience, and demonstrated competency prior to approval.

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, delineating privileges should match those 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 LP's 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). Upon recommendation from the MEC Chair, the CEO may grant temporary privileges for not more than 120 days in total.

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 requires immediate clinical privileges be granted; or 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 the necessary information 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 LP's file in the current credentialing software as File Type: Memo/Correspondence.

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

<u>According to IHS, what is a complete, clean file for expedited review and approval?</u>
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:

- A complete medical staff application with verified and documented evidence of current competence, character, judgment, education, training, and licensure.
- No current or previously confirmed challenges or restrictions on **any** state license, certification, or registration.
- No subjection to involuntary termination of medical staff membership at another organization.
- No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges.
- No "yes" responses to the professional practice questions on the IHS Medical Staff Application(s.)
- No "yes" responses to disciplinary actions for medical education, internships, residencies, or fellowships.
- No "yes" responses on peer references and/or affiliation verifications that correspond with findings on IHS high-risk credentials.
- National Practitioner Data Bank (NPDB) and Office of Inspector General (OIG) queries with no reports or negative findings.
- Previous IHS Exit Clinical Performance Summary has no adverse findings, if applicable.

Only LPs with a complete and clean file (as defined in this manual) may be considered for temporary privileges or expedited review and approval. Temporary privileges shall adhere to the facility's accrediting

body's standard requirements, the facility's medical staff bylaws and policies, the agency's 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.

Credentialing by Proxy

To operate a compliant and successful credentialing by proxy (CBP) program, IHS facilities must adhere to the standards set by their accreditation organization, the facility's medical staff bylaws, and the Centers for Medicare and Medicaid (CMS) Conditions of Participation (CoPs), as applicable. The CBP standard work in this SOP meets the Medicare CoPs requirements and The Joint Commission (TJC) 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 provides instructions for CBP remote telemedicine practitioners who will provide clinical care to IHS patients in 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. However, MSPs should carefully read the contract and comply with any credentialing-related requirements outlined within it.

Credentialing by proxy provides significant operational and clinical benefits within telemedicine programs. Specifically, it:

- Expands patient access to specialized health care services, particularly in very remote or underserved facilities.
- Reduces administrative burden by streamlining the credentialing and privileging processes for the originating site (OS)—where the patient is located—and for clinicians, especially in cases involving large numbers of physicians or licensed practitioners delivering telemedicine services.
- Recognizes the expertise of the distant site (DS), which often maintains more current and relevant information to support privileging decisions in specialized areas where the OS may have limited experience.
- Enhances cost efficiency and quality of care, as telemedicine has been demonstrated to lower overall health care costs and improve management of chronic diseases through timely access to specialty care.

The CBP process establishes a streamlined pathway for the OS to accept the credentialing and privileging work completed by a Medicare-participating hospital or a DSTE for remote telemedicine practitioners. This approach eliminates the need for the OS to conduct the full traditional credentialing process for practitioners who will not physically provide services onsite. While use of the CBP process is not mandatory for credentialing DS telemedicine practitioners, it has been the IHS preferred method since 2012 due to its efficiency and alignment with telemedicine standards. Practitioners who provide in-person or onsite services must, however, undergo the full traditional credentialing and privileging process in accordance with IHS policy and applicable regulations.

The elements below outline the minimum requirements for credentialing by proxy. If the facility's or Area's CBP Agreement, bylaws, policies, or contract impose stricter requirements than those outlined in this SOP, stricter provisions must be followed.

- 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 its own credentialing and privileging decisions regarding DS telemedicine practitioners.

- All CBP providers must be initially appointed and privileges approved for a period of one year, followed by reappointment every two years. The MEC must recommend these actions, and the GB must approve them. Facilities and Areas are encouraged to use Virtual Committee to document recommendations and approvals.
- If facility and/or Area Agreement, bylaws, and policies allow, new privileges only need to be collected when the provider's DS or OS privileges change.
- 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. The IHS CBP Intake Form is an OMB-approved form that allows for the electronic collection of CBP provider information through MD-App. This intake form is optional.
- MSPs need to ensure that the DS performs full credentialing and privileges providers according to CMS and TJC standards. MSPs may request evidence of this, beyond the distant site eligibility documentation (see below), including complete applications, credentialing-related documents, policies, and procedures. An exception to this is provider NPDB reports, queried by the DS. Credentialing by proxy is a form of delegated credentialing. In a delegated credentialing arrangement, the OS is not considered part of the DS's credentialing process and is prohibited from receiving DS NPDB query reports.
- Background/security checks for CBP practitioners will comply with the Agreement.
- Quality Assurance, Ongoing Monitoring, FPPE, and OPPE:
    - The OS will monitor the performance of practitioners covered by the Agreement and report, to the extent permitted by Federal law, all adverse events and patient and staff complaints to the DS within the time specified in the Agreement. These reports may also serve as the provider's FPPE and OPPE.
    - To the extent permitted by federal law, 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.
    - As covered by the written agreement, the DS will provide the OS with yearly quality assurance information (these can be summaries) for individual practitioners to use in reappointment decisions.
- An Exit Clinical Performance Summary (ECPS) will be completed when a CBP provider leaves the facility or Area.

Standard Work – Credentialing by Proxy

The following documents and verifications are required for the CBP process:

- Credentialing by Proxy Written Agreement – The OS must enter into a written agreement with the Medicare-participating organization or a DSTE that satisfies all CMS CoPs. 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. An IHS CBP Agreement template, recommended by OGC, is available for use by facilities and Areas. The CBP Agreement can include

one or multiple IHS federal facilities or Areas. Follow the guidance outlined in the Agreement regarding the required frequency or conditions for updates to the Agreement.

- Distant Site Eligibility – 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 the DS accreditation award letter, as well as policies and procedures related to telemedicine credentialing. The DSTE is a Medicare-participating organization or satisfies all CMS final rule CBP requirements. If the documentation proving DS eligibility (accreditation award letter) has an expiration date, updated documentation must be obtained prior to expiration.
- Schedule 1 Roster – The DS submits a schedule 1 roster that includes all practitioners who will be practicing at the OS, and have had their credentials verified and privileges approved by the DS. Any time LPs are removed or added to the schedule 1 roster, a new 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 completed all IHS-required documentation and verifications for a CBP LP.
- DS Decision Notification Letter – A copy of the DS LP's appointment decision notification letter is required to document that the DS currently approves the practitioner to perform privileges. An updated copy of the DS decision notification letter and associated privileges will be obtained prior to the provider's appointment expiration date listed on the document.
- Privileges – A copy of the DS LP's approved privileges is obtained, which may be either 1) a copy of the requested IHS area/facility-specific privileges or 2) the CBP Agreement listing 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 those granted to the practitioner by the DS. IHS telemedicine privilege forms need to be built in MD-Staff so they can be electronically recorded. New privileges need to be collected when the provider's DS or OS privileges change and as indicated by the CBP Agreement.
    - 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."
- Credentials Collection and Monitoring – One active state license held by the CBP provider will be verified and managed in MD-Staff. Board certifications, other licenses, or registrations (DEA, CDS, additional state licenses, etc.) are monitored by the DS and do not need to be collected and monitored by IHS MSPs.
- National Practitioner Data Banks (NPDB) Query Report – Each DS practitioner on the schedule 1 is enrolled in NPDB Continuous Query 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. An NPDB query report will be uploaded into MD-Staff at OS reappointment or every two years, even if the provider is enrolled in NPDB Continuous Query.

Document Storage in MD-Staff

Follow this SOP's guidance 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 LPs:

- Demographic tab (Shared)
  - First name
  - Last name
  - Degree *(needed for reports)*
  - Salutation
  - Birth Date
  - Social Security Number *(needed for NPDB CQ)*
  - Field of Licensure *(needed for reports)*
  - Cell Phone
  - Email Address
- Appointment tab (Facility-Specific)
  - 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.
  - Application Submitted - Pre-populated by the system when MD-App CBP Intake Form is used; otherwise, enter the date the information from the DS was provided.
  - Application Received - Pre-populated by the system when the MD-App CBP Intake Form is used; otherwise, enter the date the information from the DS was entered into the system.
  - Application Type – Select Credentialing by Proxy
  - Application Reason – Select Staffing Need
  - Application Status – Select Schedule One
  - Application Processed – Enter the date the MSP completes all required verifications for CBP (State license, NPDB CQ enrollment, and privileges recorded) and receives all the necessary documentation (release, DS and OS privileges, schedule 1, and decision notification letter.)
  - Initial Appointment– Enter the date that the LP was first added to the schedule 1 roster by the GB chair or designee
  - Board Approval – Enter the date the schedule 1 Roster was last approved by the GB chair or designee
  - Last Appointment – Enter the date that the schedule 1 roster was last approved by the GB chair, or designee
  - Next Appointment – Enter the date of the next appointment, also known as the reappointment date
  - Credentialing Complete – Check this box when the GB has approved the schedule 1 on which the practitioner is listed for the first time.
  - Status – Select Associate (Consultant/Courtesy)
  - Category – Select Credentialing by Proxy
  - Department 1 – Choose the department that the LP will be working within (Example: Radiology is the designated department for teleradiologists.) Do NOT choose "Telehealth"
  - 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)
  - On Staff – Check this box when the GB has approved the practitioner on the schedule 1. Once this box is checked for any LP, it should never be unchecked.

- Address (Shared) - Add any Addresses to the Address tab
- License/Credentials (Shared) - Add the state licenses in the License/Credentials tab and PSV.
- Verification Log – Add the NPDB query report
- Files (Facility or Global)
    - IHS Conditions of Application and Release – Signed by the LP. Store this document in the Files section under Statement of Release.
    - 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 in the Agreement) for each practitioner in the practitioner's Files section in MD-Staff:
        1. Add
        2. Type: Decision Notification Letter
        3. Facility: Global
        4. Description: Distant Site Appointment Letter
        5. Expires: Enter the expiration date of the LP's appointment at the DS to correspond with the DS appointment cycle. Note: an alarm should be implemented in MD-Staff to alert at least 90 days before the LP's DS appointment expiration.
        6. Upload File
        7. Save
    - Facility-specific privileges request form from each individual DS practitioner (if the OS services and privileges are not delineated in the Agreement).
        1. Add the document in MD-Staff: in the Files section of MD-Staff under "Requested Privileges."
        2. Record privileges in MD-Staff in the "Record Privileges" section under the Jump To tab.

Accreditation and Regulatory Survey Tips

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

CBP Resources

- CMS Medicare Conditions of Participation Standards for Hospital: §482.22
- NAMSS ATA Credentialing by Proxy: A Guidebook 2022

Emergency and Disaster Privileges

Emergency Privileges
The medical staff grants emergency privileges to LPs already holding privileges at IHS to allow them to perform procedures or provide care outside their scope of privileges to save a patient's life, limb, or organ. Emergency privileges provide temporary authorization to LPs when patients are in extremis. These privileges are relinquished once an LP with permanent authorization to provide the procedure or care is available, or the emergent need has been resolved. Emergency privileges are temporary privileges granted in an urgent situation. The CEO may grant emergency privileges on the recommendation of the medical staff or the chief of staff.

Disaster Privileges
When the disaster plan has been initiated, disaster privileges are granted to LPs who are not medical staff members so that non-IHS staff can provide patient care services in the service unit. When an 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 specific LPs based on proper identification and their membership in 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 must determine how the LP's performance will be supervised. Within 72 hours, the medical staff must decide whether or not his or her disaster privileges will be continued based on a practitioner's performance. Note that disaster privileges automatically expire when the disaster concludes.

MSPs should review IHS policy and the medical staff bylaws regarding emergency and disaster privileges to ensure they understand and implement the differences 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 anticipate they are unable to handle the immediate patient needs due to a disaster, a declared public health emergency, or a 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 current valid picture identification card issued by a State, Federal, or regulatory agency of the LP.

2. Evidence of one of the current clinical qualifications:
    a. current and valid IHS or non-IHS healthcare facility-issued photo identification
    b. current license to practice
    c. identification indicating the individual is a member of a disaster medical assistance team
    d. 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)
    e. attestation by current facility or medical staff member(s) with personal knowledge of the practitioner's clinical qualifications

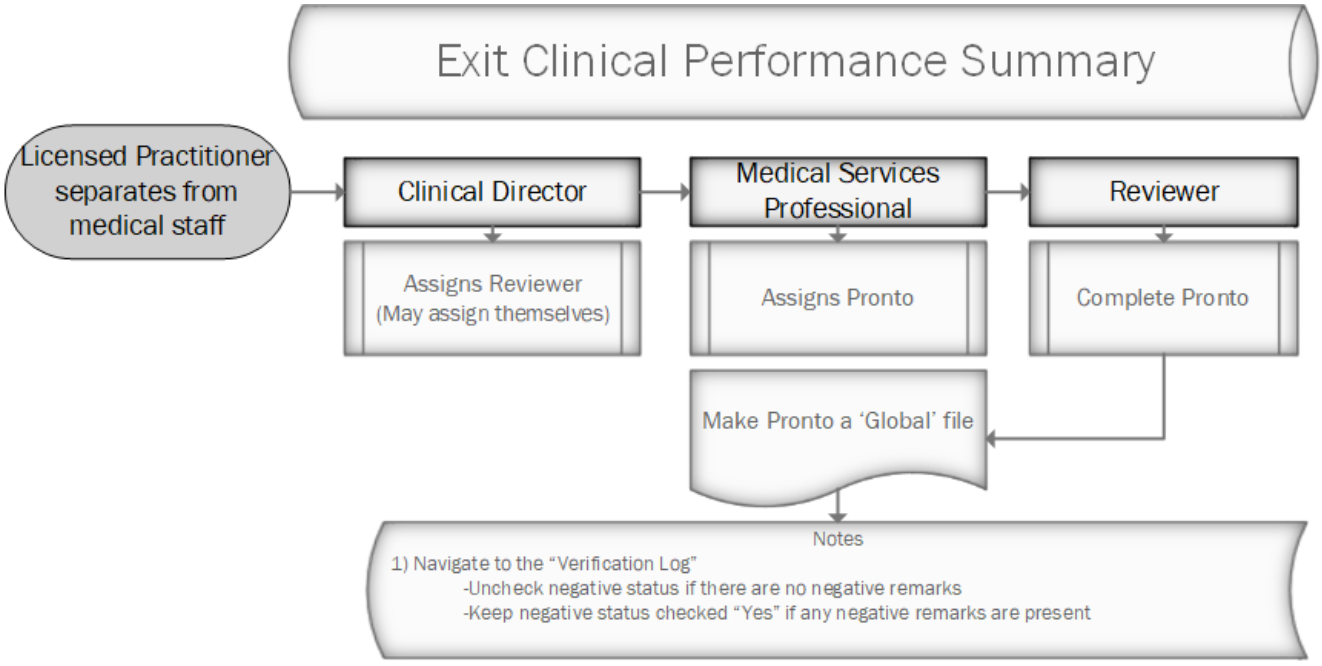
Primary source licensure verification should occur as soon as possible and, at most, within 72 hours from when the volunteer LP presents to the facility. If primary source verification cannot be obtained within 72 hours, the facility will document the reason(s) it could not be performed every 72 hours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

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

Exit Clinical Performance Summary (ECPS)

The ECPS is completed whenever a credentialed and privileged licensed practitioner (LP) leaves a federal IHS facility, whether voluntarily or involuntarily. This applies to IHS employees, contractors, credentialed by proxy providers, and those transitioning to tribal operation under 638. The ECPS records an objective summary of the LP's clinical performance and professional conduct at the time of departure, such as employment dates, clinical competence, quality of care, conduct, and final recommendations. . The Clinical Director (CD) is responsible for ensuring completion of the ECPS and may designate a peer to complete it. Documenting this information supports continuity and transparency in future credentialing decisions, allowing other IHS facilities to review a practitioner's prior performance. The ECPS is an internal, confidential IHS document protected under 25 U.S.C 1675. ECPS forms are shared only within IHS and must not be disclosed to the provider or external entities.

ECPS Process Map and Documentation Process:

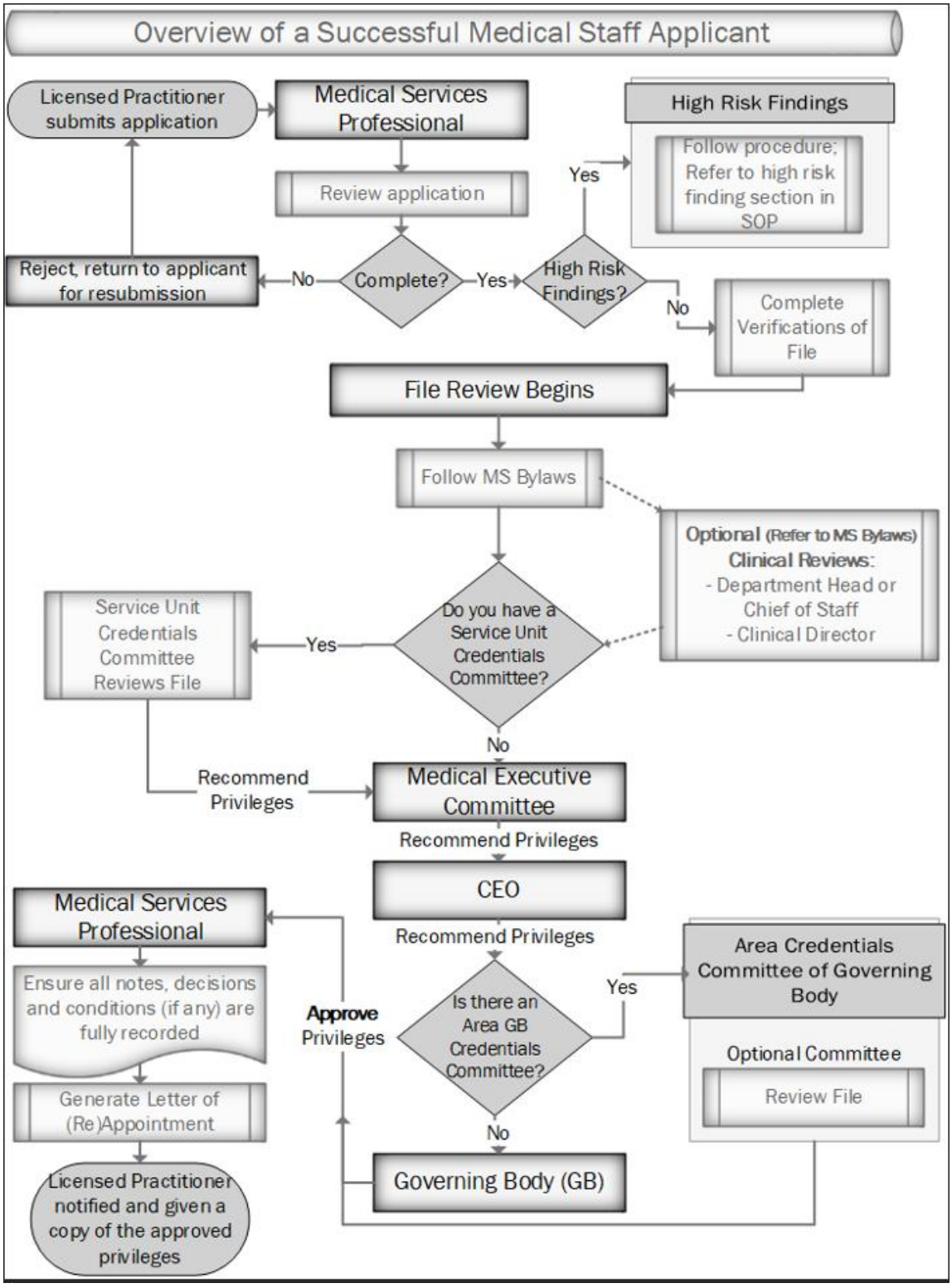


1. The MSP will set up a document bundle for their facility so that they can send the Exit Clinical Performance Summary pronto:
    a. In MD-Staff, go to Setup -> Files -> Document Bundles
    b. Click Add
    c. Fill in the following fields:
        i. Edit Bundle Name – Choose a name for the Exit Clinical Performance Summary Bundle
        ii. Message Template – Choose Exit Clinical Performance Summary Request
        iii. Available Prontos – Choose Exit Clinical Performance Summary

iv. 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 LP's profile
    b. Click on the Hospitals 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) who 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 it in the LP's Files section as File Type—Exit Clinical Performance Summary, list the Facility Name in the Description and set the File as a "Global" document.

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


Overview of a Successful Medical Staff Applicant
Licensed Practitioner submits application
Medical Services Professional
Review application
Complete?
No
Reject, return to applicant for resubmission
Yes
High Risk Findings?
Yes
High Risk Findings
Follow procedure; Refer to high risk finding section in SOP
No
Complete Verifications of File
File Review Begins
Follow MS Bylaws
Optional (Refer to MS Bylaws)
Clinical Reviews:
- Department Head or Chief of Staff
- Clinical Director
Do you have a Service Unit Credentials Committee?
Yes
Service Unit Credentials Committee Reviews File
No
Recommend Privileges
Medical Executive Committee
Recommend Privileges
CEO
Recommend Privileges
Is there an Area GB Credentials Committee?
Yes
Area Credentials Committee of Governing Body
Optional Committee
Review File
No
Governing Body (GB)
Approve Privileges
Medical Services Professional
Ensure all notes, decisions and conditions (if any) are fully recorded
Generate Letter of (Re)Appointment
Licensed Practitioner notified and given a copy of the approved privileges

Change Process, Monitoring, and Attestation

Change Process

The Credentialing Change Control Workgroup (CCCW) is an advisory group of a minimum of five members. The workgroup comprises credentialing subject matter experts, clinical staff, and the agency's Chief Medical Officer. Members of the initial CCCW were developed from the SOP workgroup. The CCCW exists to collect, review, and approve/reject change requests for the IHM 3-1 policy, the IHS Credentialing and Privileging SOP manual, Office of Management and Budget (OMB) approved applications, forms, tools, and credentialing software content. Meetings will be conducted as needed when critical change requests are received. Critical is defined as change requests affecting patient safety outcomes, credentialing, accrediting, certifying, and changing industry standards or regulations. Otherwise, meetings will occur semi-annually. At least half the workgroup members must approve the change request before it is submitted to the agency CMO for approval. The workgroup shall maintain records of meetings, action items, and outcomes.

To propose suggestions and/or edits to these documents, submit the CCCW change request form (Microsoft Teams Link, must be behind the IHS firewall to access) or complete the CCCW change request form (Appendix) and email the proposed suggestions and/or edits to IHSCredentialing@ihs.gov. The CCCW will review the proposed changes to ensure compliance with accrediting, certifying, regulatory, and industry standards.

Once a form is submitted, the information is reviewed by an HQ OQ Credentialing and Privileging Coordinator to identify the criticality of the change and determine whether the review can wait until the semiannual meeting or if a more immediate meeting is required. The information from the change submission form is tracked through completion, along with all other credentialing-related changes.

Authorities**:** IHM 3-1.2 C. (2), 3-1.3 H.

Monitoring

MD-Staff Provider Audits: Beginning October 2024, the IHS Headquarters Office of Quality Credentialing Program initiated quarterly provider audits to monitor facility and area compliance with the IHS Credentialing SOP and Policy. A total of ten files consisting of initial appointments, reappointments, or credentialing by proxy, completed in the last 90 days from each IHS Area are chosen randomly through a global ad hoc report. Audit Forms have been created based on the IHM 3-1 policy and include the SOP standard work elements and standardized MD-Staff fields. Once an audit is complete using the Audit Form the facility or area is emailed the audit outcome. The facility or area is expected to correct any findings reported within 10 business days if applicable. Provider audit outcomes are compiled and submitted biannually to the Office of Quality Leadership and the IHS Headquarters Executive Leadership Team.

Internal Control Reports: An internal control report is a document that monitors credentialing-related information and verifications on a weekly or monthly basis to ensure that areas and facilities adhere to credentialing requirements. See Section 6: Credentials Verification Processes for standard work and software documentation processes for each credentialing element, ensuring that information and verifications are recorded to align with the criteria used to generate the reports. Credentialing-related

reports, including information, verifications, and expiration reports, may be modified in response to requests from IHS leadership and the Agency's needs.

Non-compliant findings are emailed to the Area MSP Lead to facilitate communication and coordination of applicable updates with the facility. A timeline for a response is included in the email per IHS Headquarters' request. Communication is made to the Deputy Director for Field Operations, Area Director, Area Chief Medical Officer, the facility's Clinical Director, and the Chief Executive Officer for continual non-compliant findings.

Annual Attestation

All IHS facilities must implement the IHS IHM 3-1 policy and the SOP standard work elements. Every year each facility is required to complete an Annual IHS Credentialing Attestation. The IHS Headquarters Office of Quality Credentialing Program will email each facility with an attestation link, due date and instructions for completion. In completing the Annual IHS Credentialing Attestation, each facility will be able to self-assess credentialing-related strengths and areas for improvement. Implementation status is reported using the Annual IHS Credentialing Attestation.

Frequently Asked Questions

This section provides a listing of frequently asked questions by IHS MSPs. Some questions can fit into more than one category of FAQs but attempted to place them in the category associated with the main topic of the question. However, credentialing questions can have multiple parts; please consider multiple categories to review. If this section does not answer your question, contact your Lead Area MSP. If your Lead Area MSP does not know the answer, they should contact the Area CMO before contacting the OQ Credentialing Program. Questions regarding the credentialing software should be directed to MD-Staff Customer Support Help Desk at 1-800-736-7276 or support@mdstaff.com.

- Application FAQs
- Appointment/Reappointment FAQs
- Board Certification FAQs
- Commissioned Corps TDY/Detail FAQ
- Contracts/Hiring FAQs
- Documentation FAQs
- File Management/Sharing FAQs
- Forms FAQs
- Licenses/Credentials FAQs
- Malpractice FAQs
- Professional Practice Evaluations FAQs
- Verification FAQs

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 for the most part, with each adhering to distinct requirements, processes, standards, and regulations that may not apply to the other. Consequently, all employed LPs undergo two separate onboarding procedures tailored to these different areas. For onboarding, employed LPs are selected and hired through the HR process. In contrast, contract LP staff are onboarded through the contract onboarding process. Contract companies and/or individual contracted LPs are selected and paid through the Division of Acquisitions Management.
Both employed and contracted LPs must pass a background clearance conducted by 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 vacancy announcement or contract will provide a list of requirements for the position. 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 is not qualified 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.

Obtaining and maintaining membership and/or clinical privileges is crucial for medical staff. Failure to secure these continuously upon hire or to maintain them 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 LP has left the first IHS facility and is applying to a second IHS facility. Does the LP need to complete another application? If so, would it be an initial or reappointment?
A: Yes, the LP will need to complete a new initial appointment application for the second IHS facility. There are multiple reasons for this:

- The application allows the LP to update or add outdated or new information.
- The application requires the LP 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 assess the qualifications of each application for appointment and privileging. The MEC evaluates current competency, determines the appropriateness of requested privileges, and recommends appointment and privileging decisions based on needs, bylaws, and policies.

Q: How does an LP submit an MD-App application if they cannot complete a required field? (For example, the middle name field within the application is required, but the LP does not have a middle name.)
A: When the LP submits the application, a pop-up will list the remaining required fields that are not populated. The LP will need to click the + and explain in the comment box why they cannot complete the required field. Once all items on the pop-up have an explanation, the LP can submit the application.

<u>Appointment/Reappointment FAQs</u>

Q: If an LP 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 bylaws and policies for this. If the bylaws are silent on this and there are no policy requirements, the LP may utilize the reappointment form and process if the lapse or gap in service is no longer than one year.

Q: Can the GB sign the appointment file and select a future date 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. Suppose the resident participates in an official residency program with a MOU/A at an IHS area/facility in a training capacity only. In that case, IHS does not require these individuals to be credentialed and privileged unless the MOU/A requires it. However, the residents must still be supervised and communicated with the residency program. 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 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, Physician Assistants, and Advanced Practice Registered Nurses. Other allied health professions may be credentialed and privileged, as defined by the Indian Health Manual, the local facility and/or Area bylaws, and accrediting body standards.

Q: If a provider's appointment and privileges expire on 2/15/2025, but the GB approves the appointment on 2/16/2025, is this considered a lapse in appointment and privileges?
A: Yes. The GB needs to approve a provider's privileges and/or appointment on or before the appointment/privileges expiration date to prevent a lapse.

Board Certification FAQs

Q: What evidence do LPs 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 eligibility requirements with the specified board, they meet the requirement to be board-eligible for IHS.

Commissioned Corps TDY/Detail FAQs

Q: A Commissioned Corps Officer is being assigned to our facility in a TDY or detail. Does the medical staff office need to credential and privilege them?
A: If the officer will be working in a clinical role and the facility's bylaws require the profession they are working in to be credentialed and privileged, then they will need to be credentialed and privileged.

Q: Is a Commissioned Corps Officer serving in a detail or TDY set up by Commissioned Corps Headquarters to IHS facilities covered by FTCA?
A: Yes.

Contracts/Hiring FAQs

Q. The Tribe contracted/compacted clinical services, e.g., dental and behavioral health services. However, the Tribe still uses the federal facility to provide these services. Who is responsible for the credentialing and privileging of these LPs 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 appointments/privileges?
A: For locum tenens, read the contract or ask the contracting officer to 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. The provider will only have a one-year residency (transition year) in general medicine, and their privileges are very basic.

Q: Is a contract LP 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 is 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.

Q: Do MSPs need to confirm that the background investigation is current before proceeding with re-credentialing?
A: No, the HR and Medical Staff Office processes are separate processes; the credentialing process should proceed.

Documentation FAQs

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

A: If the LP 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 LP also works with [Other Company Name].

Q: Can the credentialing software be used to track other non-credentialed and privileged professionals within the facility with licenses, registrations, or certificates that the facility needs to track?
A: Yes, while not required, if the service unit and/or area request 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. Healthcare providers with credentials files maintained in the same system and who do not have clinical privileges must be designated as Category "No Privileges" in the software. See the Operations Definition Guide on the C&P SharePoint site for additional fields that must be completed. The most recent guide is found in the Standardization > Job aids > Status-Category Switch document.

Q: Can registered nurses and other licensed staff not part of the medical staff be tracked in the credentialing software to take advantage of the software's monitoring abilities?
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 Records Disposition Schedule. 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 with the Agency's Records Deposition Schedule.

Q: Our facility transitioned from IHS to tribal assumption via 638. Can we dispose of the credentialing records for providers that were affiliated with the facility when it was an IHS facility?
A: The credentialing records can be disposed of if they meet the Credentialing Records Disposition Authority. Paper and electronic credentialing records for employed providers must be retained for 10 years after they leave the facility. Records for providers who were not selected or rejected as applicants need to be retained for 3 years.

Q: What is the process when LPs ask for credentialing information from their credentialing file?
A: A copy of any information the LP provided to IHS can be returned to them. Any information or verifications received from organizations or others, including peer references, cannot be provided to the LP.

Q: What is the process when IHS staff ask for credentialing information from an LP's credentialing file?
A: For IHS MSPs, the Sharing Document identifies what documents will 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: What is the process when individuals outside of IHS ask for credentialing information from an LP's credentialing file?
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 the IHS HQ Privacy Officer for official determination.

Q: Our facility has a credentialing by proxy (CBP) agreement that requires monitoring of only one active state license for providers that are CBP. Per the new CBP agreement (July 2025), the distant site credentialing is responsible for monitoring all other active licenses, registrations, and board certifications. However, the provider's MD-Staff profile contains all of their active state licenses, registrations, and board certifications. Since I don't need to monitor these additional credentials, how do I manage these in MD-Staff? What if the provider is affiliated with another IHS facility in MD-Staff?
A: If the provider is only affiliated with your facility, the "In Use" box for the unmonitored credentials can be unchecked so that they don't appear on alarms or reports, unless your bylaws require tracking these credentials for CBP providers. If the provider is shared with another facility, it is best to contact the other facility to agree on how to manage the credentials. Some providers that are shared with other facilities can be fully credentialed and privileged at that site and unchecking the "In Use" checkbox may cause them to miss their verifications.

Q: Accrediting body surveyors arrived at my facility for a survey. One of the surveyors is requesting to view the NPDB query report for a provider. Can I provide the report to them?
A: No, per the NPDB, surveyors may not view NPDB query reports or any document that the facility has obtained from the NPDB with confidential results. However, the NPDB Query History or Manage Continuous Query Subjects list can be shared with the surveyor. This information is communicated in the NPDB Guidebook under General Information and Appropriate Use of NPDB Information.

Q: Is a release of information required to run an NPDB query report?
A: No, as a registered entity with the NPDB, a signed release of information from a provider is not required to query the NPDB.

Forms FAQs

Q: Why can't facilities develop their own forms for credentialing and privileging?
A: The Paperwork Reduction Act of 1980 is a federal 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 and then upload them 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. Using the software to complete the privilege forms by the applicant allows for fewer errors in data entry transfers.

Once imported, the privilege selections automatically populate the LP's profile. If it is necessary to use a paper privilege form, the MSP must also record those privileges in MD-Staff.

Q: Can privilege form content be modified?
A: Yes, privilege forms can be modified. However, modifying active privilege forms will impact any LPs 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 "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 their entirety or parts of it. Some facilities have provided privilege forms on the IHS HQ Credentialing SharePoint, or you can ask another service unit for an "X" privilege form during Office Hours. To import privilege forms or parts of a privilege form, 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 can choose which text, criteria, and privileges they would like to add by clicking the plus button.

Licenses/Credentials FAQs

Q: Where does it document that licensed practitioners can be licensed in ANY state and work for the federal government?
A: Licensure requirements in the IHS are established in federal law, personnel regulations, and IHS policy circulars:

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 by 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, dated June 5, 1996.

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 where they provide services in a federal facility?

A: Federal licensure requirements in federal agencies, including the IHS, are established in Federal law and personnel policy. Federal law at 25 U.S.C. § 1621t states that licensed health professionals employed by a tribal health program are exempt if licensed in any state, from the licensure requirements of the state where services under an ISDEAA agreement are performed.

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.

Malpractice FAQs

Q: How do MSPs respond to outside affiliation requests regarding FTCA coverage and malpractice history?
A: If outside organizations ask for a claims history or verification of malpractice insurance coverage of current or previously employed LPs, send the Agency FTCA Letter or direct them to the IHS Risk Management internet page, Resources | Risk Management (ihs.gov). A link provides information through an agency letter entitled "Outside Requests for FTCA Coverage Verification and Claims History." This letter explains that IHS LPs are covered by FTCA during their employment, within the scope of their official duties. In addition, we can provide the requestor with the MD-Query information, and they can log on and obtain the affiliation verification that will list their affiliation dates 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 desire to contribute to health care in an underserved population?
A: No. 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 typically provides malpractice coverage through its insurance carrier or 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 LPs?
A: No. Under the FTCA, the federal government acts as a self-insurer, recognizing liability for its employees' negligent or wrongful acts or omissions acting within the scope of their official duties. FTCA provides coverage for federal employees, not locum tenens LPs.

Professional Practice Evaluations FAQs

Q. Can a physician assistant complete chart reviews for a nurse practitioner?
A. It depends on their medical staff's 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 LPs participate 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 LP being reappointed has been participating and the outcomes of the LP's OPPE/FPPE.

Q. Can an APRN and PA provide a peer reference on initial and reappointment applications for each other?
A. No. If the medical staff office is struggling to find an appropriate peer, it is recommended that they find a peer at another service unit and request that they complete chart reviews and peer references.

Verification FAQs

Q. If an applicant was contracted/employed with a health system and provided a verification listing all the facilities where they held privileges, does the applicant need to list all the facilities separately on the application?
A: Yes. The applicant must list all practice history since medical school graduation.

Q. A provider who completed his internal medicine residency in 2019-2022 is now the same university's chief resident. Would his chief residency be verified as education/training or an affiliation?
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 an MSP verify a training program or previous affiliation/employer that has closed?
A: Reach out to a previous employer and ask if they could obtain verification from the program/employer before it closed. 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 affiliations where they worked as a registered nurse verified, or just the APRN experience?
A: Only verify affiliations for APRN experience.

Q: How are expired credentials managed while the LP's file is in a review process?
A: The MSP must verify all expirables upon expiration and place the documentation in the file. The MSP must continue monitoring expirables even during the review process and always provide the most current information.

Q: Is employment at other affiliations within IHS verified?
A: Yes. Use MD-Query. Login credentials and passwords for all IHS facilities are on the IHS HQ Credentialing SharePoint site.

Q: I need affiliation letters for a new LP who has previously worked at multiple IHS facilities. I tried obtaining these through MD-Query, but after I ran the first affiliation letter, I kept getting website errors. How do I resolve this?
A: Be sure to clear your browsing history after each MD-Query request. If there are still problems obtaining the affiliation letter, check to ensure the correct URL and login information are being used.

Q: Why might a provider's appointment date for clinical privileges differ from the provider's employment start and end dates?
A: MD-Query reflects the provider's appointment dates as recorded in MD-Staff, not the actual service dates. Upon a provider's resignation, the appointment cycle end date is not retroactively amended unless there is a formal early termination or revocation action. Therefore, dates on the MD-Query letter are from the provider's approved credentialing file cycle and may not precisely match those on an HR personnel file.

Q: Can I send affiliation verifications to locum companies to verify on behalf of the hospitals or clinics associated with the LP?
A: No. Affiliation verifications must be sent/received from the primary source (hospital or clinic) where the LP 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 unwilling to complete the verification or is non-responsive after 3 attempts, this should be noted as a red flag.

Q: An LP works at an IHS facility, resigns, and then is rehired at the same IHS facility. Does the MSP have to fill out an affiliation verification for their facility for this returning LP?
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. These documents may include an Exit Clinical Performance Summary and old medical staff documents (credentialing files, professional practice evaluations, etc.)

Q: I verified OIG for an LP at our facility in MD-Staff. The report came back with a red flag. However, after further investigation, the OIG report has the wrong individual on it. How do I manage this?
A: Complete a manual OIG verification at the following website: https://exclusions.oig.hhs.gov/. Take a screenshot of the website results to show that OIG does not flag the LP in question and add the verification to the Verification Log. Delete the OIG verification that reports the wrong individual.

Q: A dentist submitted an initial application for an appointment. When the MSP reviewed the work history, the dentist documented in the application that she owned their own dental practice business where she worked as a dentist. How should the MSP manage verifying this work history?
A: Providers that own patient care businesses often do not have someone supervising or overseeing their clinical work. If the business is still open, ask the provider if there is anyone employed at the facility that could verify employment history information, such as a human resources officer. If not, the MSP could rely on peer references if another dentist worked at the facility. If the dental practice is no longer in business and there is no way to verify the information, the MSP should document this information.

Q: Why is verifying the nurse practitioner license alone insufficient?
A: A nurse practitioner license typically cannot be maintained without an active RN license. However, to mitigate risk, verifying all active RN licenses helps identify any underlying Issues or suspensions that may not yet be reflected in the NP license.

Q: A provider submitted a DEAX registration (DATA-waiver) to prescribe buprenorphine for the treatment of opioid use disorder. Does this registration need to be primary source verified?

A: If an LP's state license requirements align, Section 1262 of the Consolidated Appropriations Act of 2023 removes the federal requirement for practitioners to apply for a DEAX buprenorphine registration before prescribing buprenorphine for the treatment of opioid use disorder. (Do not need to track or document DEAX but need to PSV DEA.)

Record of Significant Changes

Version, Date, & Description	Section
1.0; Sept 2005 Initial Draft	All
1.0; Sept 2024 Publication	All
3.0; Oct 2024 Integrated field feedback	• Page 5: Added yearly attestation requirement. • Section 6, pages 47-48: Removed form validity for 1 year.
4.0; Nov 2024 Integrated field feedback	• Section 6: Changed the requirement to primary source verify the last five years of malpractice insurance to verify the current malpractice insurance and review of information provided on the application to assess malpractice history and claims. • Section 8: Removed that releases are good for one year. • Section 6: Adjusted Education standard of work to only require verification of qualifying degree and post-graduate training.
5.0; Feb 2025 Integrated field feedback	• Section 5: Clarified that electronic signatures are acceptable on all credentialing applications, forms, and tools. • Section 6, Professional Education and Post-Graduate Training: ECFMG is required for Canadian international medical graduates starting 7/1/25. • Section 6, Professional Education and Post-Graduate Training: Providers with 5th Pathway will need to be referred to AAAC for review. • Section 6, DEA, DPS, and CDS: Clarified that at reappointment, all active DEA registrations, DPS, and CDS certifications will be verified. • Section 6, NPDB: Clarified that an NPDB query report needs to be uploaded into MD-Staff at initial appointment, reappointment, and when additional privileges are requested. • Section 6, Current Liability Insurance: Clarified that if an LP maintains liability insurance related to the IHS facility, the insurance is verified at initial appointment and prior to expiration. Also expanded the types of acceptable verifications.
6.0; May 2025 Integrated field and OQ Division of Compliance feedback	• Section 6, Updated board certification verification to include “or other nationally recognized certifying body.”

7.0; Jun 2025 Integrated field and OQ Division of Compliance feedback	• Section 5, ECPS: Clarified ECPS sharing among IHS facilities and with the provider. • Section 6, Immunizations: Removed the requirement for the collection of provider immunizations through the credentialing process.
8.0; Sept 2025 Integrated field feedback	• Section 6, Licensure and Section 13, Credentialing by Proxy: Changed the requirement to monitor all state licenses for providers credentialed by proxy to one active state license. • Section 10, Emergency and Disaster Privileges: Removed "For all LPs who were granted disaster privileges, even if their privileges with a facility have already ended, the regular application and credentials verification process must be completed as soon as possible."
9.0; Dec 2025 Integrated field feedback	• Credentialing Software Fields: Added the requirement to complete ECPS for providers hired at facilities that transfer to tribal assumptions under 638. • Credentials Verification Processes: Clarified affiliation verification for locum tenens and telemedicine LPs. • Shared Credentialing Documents: Clarified when NPDB query reports may be shared with other departments. • Privileging Process: Removed the requirement to renew temporary privileges every 30 days. • Credentialing High Risk Findings and Management: Removed recommendations for matched professional practice questions with the high risk findings requiring an ACCC endorsement. Listed the high-risk findings separately from the professional practice questions.

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