Medical Staff Credentialing and Privileging Standard Operating Procedure Manual

Indian Health Service

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Version 5.0

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This SOP Manual supersedes the IHS Medical Staff Credentialing and Privileging Guide, Sept. 2005.
Developed under the direction of the Office of Quality, Indian Health Service Headquarters

Record of Changes

Version, Date, & Description	Name	Section
1.0 Sept 2005 Initial Draft	Martin Smith, Michele Gemelas	All
2.0 Sept 2024 Publication	IHS SOP Manual Workgroup	All
3.0 Oct 2024 Incorporated comments received from the field	Dione Harjo, Christel Svingen	• Page 5: Added yearly attestation requirement. • Section 1, Page 6-7: Added Distant Site, Medical Executive Committee, and Governing Body definitions. • Multiple pages: Changed all IHS Practitioner Acknowledgement & Release entries to IHS Conditions of Application and Release. • Section 6, pages 47-48: Removed form validity for 1 year. • Section 6, Immunizations, pages 55-56: Adjusted section to include immunizations are not required for staff that do not work onsite. • Section 7, page 67: ACCC flowchart removed. • Section 11, page 90: Adjusted credentialing by proxy definition. • Section 15, page 124: New FAQ on affiliation verifications, Contracts/Hiring, and under Verifications.
4.0 Nov 2024 Incorporated comments received from the field	Dione Harjo, Christel Svingen	• Added Change Process, Monitoring, and Attestation section • Section 1: Glossary, definitions clarified • Section 5: Pre-Application title changed to Pre-Screen and clarified when pre-screen and initial applications can be sent • Section 5, page 55: Removed the standard work element for immunizations. • 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. • Section 15: Added table of contents for FAQs and added new FAQ regarding collecting immunizations for initial appointment. • Section 15: Updated and added FAQs. • Appendix: Updated audit forms.
5.0 Feb 2025	Dione Harjo, Christel Svingen	• Glossary: Added MD-Staff Entry and MD-Staff Tab definitions.

Incorporated comments received from the field		• Section 5: Clarified that electronic signatures are acceptable on all credentialing applications, forms, and tools. • Section 6: Clarified, reorganized, and added MD-Staff screenshots. • 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, IHS Conditions of Application and Release: Clarified that the IHS Conditions of Application and Release are required for initial and reappointments. • Section 6, Continuing Medical Education (CME) or Continuing Professional Education (CPE): Clarified that facilities may choose to track the IHS Essential Training on Pain and Addiction, but tracking is not required. This certificate can be stored in the License/ Credentials tab of MD-Staff. For staff exempt • Section 6, Proof of Identity: Clarified designated individuals who may complete identification verification. • Section 6, Education/Training, Experience, and Hospital/Other References: Expanded approved acceptable verifications. • Section 6, Gap Report: Clarified that an MD-Staff generated Gap Report is optional. • Section 6, Board Certification and Professional Affiliations: Clarified that professional affiliation information and medical society membership does not need to be verified. • Section 6, Board Certification: Clarified that the board certification expiration date field may be used as the recommended renewal date if the board certification does not have a designated expiration date. • Section 6, DEA, DPS, and CDS: Clarified that at reappointment, all active DEA registrations, DPS, and CDS certifications will be verified. • Section 6, CME or CPE: Clarified that continuing education does not need to be primary source 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. • Section 6, Sanctions Disclosure or Current Investigations: Added NPI verification requirements. • Section 8: Removed 120-day expiration of primary source verifications. Added verbiage to clarify the timeframe of verifications and when they can be used.

		• Section 9: Included information regarding low to no-volume providers. • Section 12, Standard Work: Expanded the approvals/signatures of appointments and privileges may include paper versions and copies need to be uploaded into the Files tab. • Section 12, Standard Work: Completed Virtual Committees are archived in MD-Staff. • Appendix 2: Included screenshot of ECPS file upload to include Facility name in description. Section 13, Standard Work: Changed the requirement to use the CBP Intake for credentialed by proxy providers to optional. • Appendix: Removed IHS Essential Training on Pain and Addiction

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How to use this SOP Manual

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

Change Process, Monitoring, and Attestation

Change Process

The Credentialing Change Control Workgroup (CCCW) is an advisory group of the IHS Office of Quality (OQ). The workgroup comprises credentialing subject matter experts, clinical staff, and the agency's Chief Medical Officer. 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. To propose suggestions and/or edits to these documents, submit the CCCW change request form and email it to IHSCredentialing@ihs.gov.

Monitoring

- Provider Audits: The IHS HQ OQ Credentialing program will conduct a minimum of 10 random provider audits quarterly to ensure that areas and facilities adhere to credentialing requirements. Audit data will be reported quarterly to the IHS Headquarters Executive Leadership Team.
- Internal Control Reports: Credentialing-related information and verifications are monitored monthly to ensure that areas and facilities adhere to credentialing requirements. See Section 6 for standardized documentation processes. Credentialing-related reports for information, verifications, and expiration may change, depending on requests from IHS leadership and the needs of the Agency.

Annual Attestation

IHS facilities are expected to implement all standard work procedures described in this manual. Facilities must complete a yearly attestation to confirm that they have implemented the IHM 3-1 policy and standard operating procedures standard work items. The annual assessment and attestation link will be emailed to each facility for completion.

Section 1: 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. For a full definition, 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 create a safe, efficient, repeatable work method to accomplish a task while simultaneously reducing waste and variability within the process.

Telehealth – A secure audio and/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.

Section 2: Credentialing and Privileging in Patient Safety

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

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

Darling v. Charleston Community Memorial Hospital: Before this case ruling in 1965, hospitals were considered charitable organizations and were immune from being sued under the Charitable Immunity Doctrine. The Supreme Court of Illinois overturned this doctrine. It introduced the idea of corporate negligence, as defined by an organization failing to meet basic standards such as monitoring, supervising, and controlling quality care. The ruling determined that hospitals should follow TJC guidelines, government standards, and organization standards to validate their LP's competency to provide high-quality and safe care. The decision affected other court cases, such as Johnson v. Misericordia Community Hospital in 1991. It illustrated the need for hospitals to be prudent in selecting LPs that provide patient care.

Darling was a football player who broke his leg during a game. He had his leg placed in a cast by the on-call doctor, subsequently developed gangrene, and had to have his leg amputated below the knee. The plaintiff claimed—and the court agreed—that the hospital was negligent for two reasons: it failed to review the work of an independent doctor properly, and its nurses failed to administer necessary tests. Darling held that the hospital bylaws, licensing regulations, and standards for hospital accreditation were sufficient evidence to establish the standard of care. Therefore, a lay jury could conclude from the evidence that the hospital had breached its duty to act as a reasonably careful hospital.

Other Credentialing Landmark Cases:

- Johnson v. Misericordia Community Hospital: The hospital was found liable for a patient injured by a physician who had failed to disclose pending malpractice cases and lied about his privileges at other hospitals.
- Frigo v. Silver Cross Hospital: The hospital was found liable for a podiatrist performing a bunionectomy on an ulcerated foot, resulting in osteomyelitis and subsequent amputation of the foot. The provider did not meet the privileging criteria to perform these procedures.
- Larson v. Wasemiller: The hospital was found negligent in approving the provider's privileges on reappointment due to the provider's poor performance (10 prior malpractice claims, state board

licensing actions, failed three times to pass board certification recertification exam). Negligence was based on what was known or should have been known at the time of the credentialing decision.

Section 3: Types of Errors in Credentialing

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

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

   Example 1: Incomplete Verification of Educational Credentials

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

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

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

   Example 2: Failure to Document Sanctions and Disciplinary Actions

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

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

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

2. **Decisional Error**—This type of error pertains to inappropriate or misguided decisions made despite concerning information. The clinical staff and leadership commit this type of error when reviewing, recommending, and approving the file. Less-than-favorable or negative information is discovered and presented, but the choice is to dismiss or ignore the concerning information.

   Example 3: Ignoring Disciplinary Actions

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

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

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

   Example 4: Overlooking Gaps in Practice History

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

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

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

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

Section 4: The Role of the MSP

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

MSPs are among the first contacts in health care delivery. They verify, analyze, and prepare all relevant information regarding an LP's competency, character, training, experience, and judgment to present a complete and accurate file to the MEC and GB for recommendations and approvals.

The MSP collects and maintains all LP files in MD-Staff, the official IHS system of record for credentialing and privileging, from the application to final approval and throughout the appointment cycles.
It's important to remember that even the most robust credentialing software systems still require human intervention. Even though LPs can complete their applications and associated documents electronically, and the credentialing software can verify information automatically, the MSPs, medical staff, and governing body still must vet the LPs' applications, credentials, and verifications.

Section 5: IHS Applications, Forms, and Tools

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

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

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

Electronic signatures are acceptable on all credentialing applications, forms, and tools.

Credentialing Applications and Tools
The following are the types of electronic applications, tools, and forms available for use in the IHS credentialing and privileging process. The use of these applications and tools is further described below.

Applications:
- Initial Application
- Reappointment Application

Tools:
- Pre-Screen
- Credentialing by Proxy Intake Form

Forms:
- Peer Reference
- Affiliation
- Education
- Insurance

Four audit tools are used by the IHS Office of Quality Credentialing Division to conduct random audits of credentialing files. Audits are based on the minimum required elements in the IHM 3-1 policy and the SOP Manual. These audit forms are excellent tools to ensure all tasks are completed within a credentialing and privileging process:
- IHS Initial Appointment Audit Form
- IHS Reappointment Audit Form
- IHS Additional Privileges Audit Form

- IHS Disaster Privileges Audit Form

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

Initial and Reappointment Applications:
The MSP must ensure the LP's information on the applications and tools is complete, accurate, and current by reviewing, analyzing, and verifying the information with primary sources (where available) and providing support for credentialing-related tasks within the medical staff office. The medical staff initial and reappointment applications are similar to a human resource job application, but there are some significant differences. Required information includes personal/individual information, education (medical/professional school), postgraduate training, licensures and certifications, specialty, work history, references, and hospital affiliations. The LP must provide information regarding malpractice insurance, malpractice claims history, and practice locations. LPs must answer disclosure and attestation questions regarding criminal history, malpractice claims history, drug use, and ability to practice in the profession. The medical staff applications also include a request for clinical privileges.

Software – Authorized Users:
Medical staff applications will only be sent to the LP applicant's email address. Applicants authorize another user directly through the software or submit a written request to send their application to another user to assist in completing it. This authorization should include the name, relationship, and contact information of the individual authorized to complete the application on LP's behalf. This authorization must be documented in the LP's MD-Staff profile under the Files section as File Type "Practitioner Provided." The authorization permits the authorized user to complete the application on the LP's behalf. However, it remains the responsibility of the LP applicant to request privileges and ensure their application is correct and complete. The "Sign and Submit" screen meets the legal requirement for the applicant to attest and agree that all information provided is true and accurate and that no material or facts have been omitted that would render the application false, factious, or fraudulent.

When should applications be sent out to the applicants?
The pre-screen tool is used to identify individuals (IHS or Contractors) who meet the minimum qualifications to receive a full application for medical staff membership and/or privileges. Only after the applicant has accepted the tentative job offer can the full initial appointment application be sent to the applicant. 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.

Initial Applications
IHS's initial appointments are one year long regardless of accrediting body medical staff standards. Only IHS OMB-approved Medical Staff Initial applications shall be used for all initial applicants.

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

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 and presents a potential risk to the agency.

1. **Initial Check – Do not risk a duplicate provider:**
    - **a.** Credentialing > MD-App > New Affiliation and search for the provider by last name (accurate spelling is crucial). **Note**: If the provider has changed their last name, they will not show on this list.
    - **b.** **Note**: The Credentialing > Advanced Provider Search only works to identify other LPs if the search is performed at the Global Market level. Do not search with the Advanced Provider Search unless you have Global Market access.
    - **c.** 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 s**elect the Checklist and Application template**.
    - **c.** **Note**: If the LPs **NPI** is unknown, look up the NPI on the NPPES NPI Registry using their name. Confirm that the degree and specialty 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.

Reappointments
For IHS, reappointments are two years long, regardless of the facility's accrediting body standards or medical staff bylaws. Only IHS OMB-approved Medical Staff Reappointment applications shall be used for all reappointments. The provider cannot provide patient care services until the practitioner has been approved for their next appointment and privilege cycle.

Software - Steps for sending a reappointment:

1. Navigate to **Credentialing > MD-App > Begin a MD-App Reappointment**
2. The *Select Provider* window will display. Use the Provider search box to 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.

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

An application is complete and ready for import when:

1. all the required fields on the application have been completed by the applicant that supports the facility's ability to verify all 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.

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.

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.

Application Tools

Pre-Screen:

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

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

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

1) Navigate to **Credentialing > Existing Appointments > Begin an MD-App Reappointment**.
2) Select the **Names** tab
3) Enter provider's name
4) Select **Next**
5) For the **Application Template,** select **Initial Application**

6) Select **the Facility or Facilities to which** you are sending the application on behalf.
7) Select what **General Documents** you will send (e.g., IHS Conditions of Application & Release and any other facility documents) to include with this application packet. *Note: To be available on this page, the documents must be uploaded through Set Up > MD-App > Documents.*
8) Select what **Privileges** you will send to the provider
9) Select the **Assigned User** and the **Checklist**
10) Select **Start**

Credentialing by Proxy (CBP) Intake Form:

A tool designed to gather 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 Section 13 of CBP below.

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

<u>Credentialing Forms</u>

IHS Peer Reference Form:

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

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

The Peer Reference (OMB Approved) Form is used for all peer references and is set up in MD-Staff globally for selection and use.

IHS Affiliation Verification Form:

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

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

IHS Education Verification Form:
The IHS Education Verification Form includes information to confirm the LP's medical degrees, specialty training, and completion of residency and fellowship programs. It is designed to capture information regarding the LP's time, completion status, clinical practice, disciplinary actions, and character to validate their education and training, assess the LP's competency, and confirm the information provided on the application.

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

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

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

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

1. Navigate to **Merge/Pronto**
2. Select **Demographic**

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

The Insurance (OMB Approved) Form is used for all insurance verifications and is set up in MD-Staff to be used globally.

Provider Release Form:
The IHS Conditions of Application and Release Form is important for credentialing and privileging. A signed release form from the LP is required to begin requesting verifications. The first page of the release provides conditions for which the LP can be held while the application is being considered and processed and as a condition of continued appointment. The second page of the form is a two-way release allowing IHS to request, obtain, and disclose information on an LP to/from the IHS to credential and privilege at an IHS facility. The release includes the OMB Burden Statement and the Privacy Act Statement.

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

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

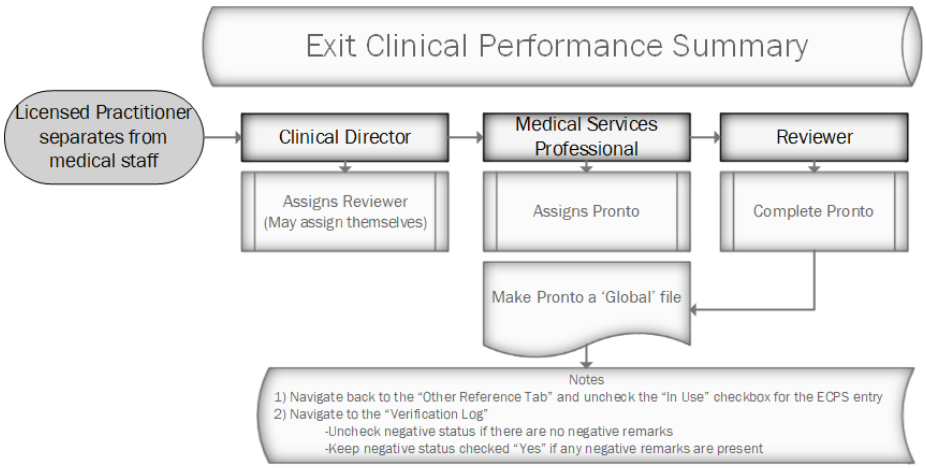
The document bundle is set up and ready to use in the associated tab in MD-Staff. For further guidance, use the MD-Staff online guides and on-demand videos, or call Support at 1-800-736-7276.

Exit Clinical Performance Summary (ECPS)
ECPS is an internal IHS document completed when a LP resigns or employment is terminated at a federal IHS facility. It provides a factual real-time record of the LP's clinical performance and professional conduct when the LP leaves the facility. Capturing this information helps the CD/CMO or department chair not try to recall (sometimes years later) how the practitioner performed. Like a Forever/Evergreen Letter, the ECPS allows

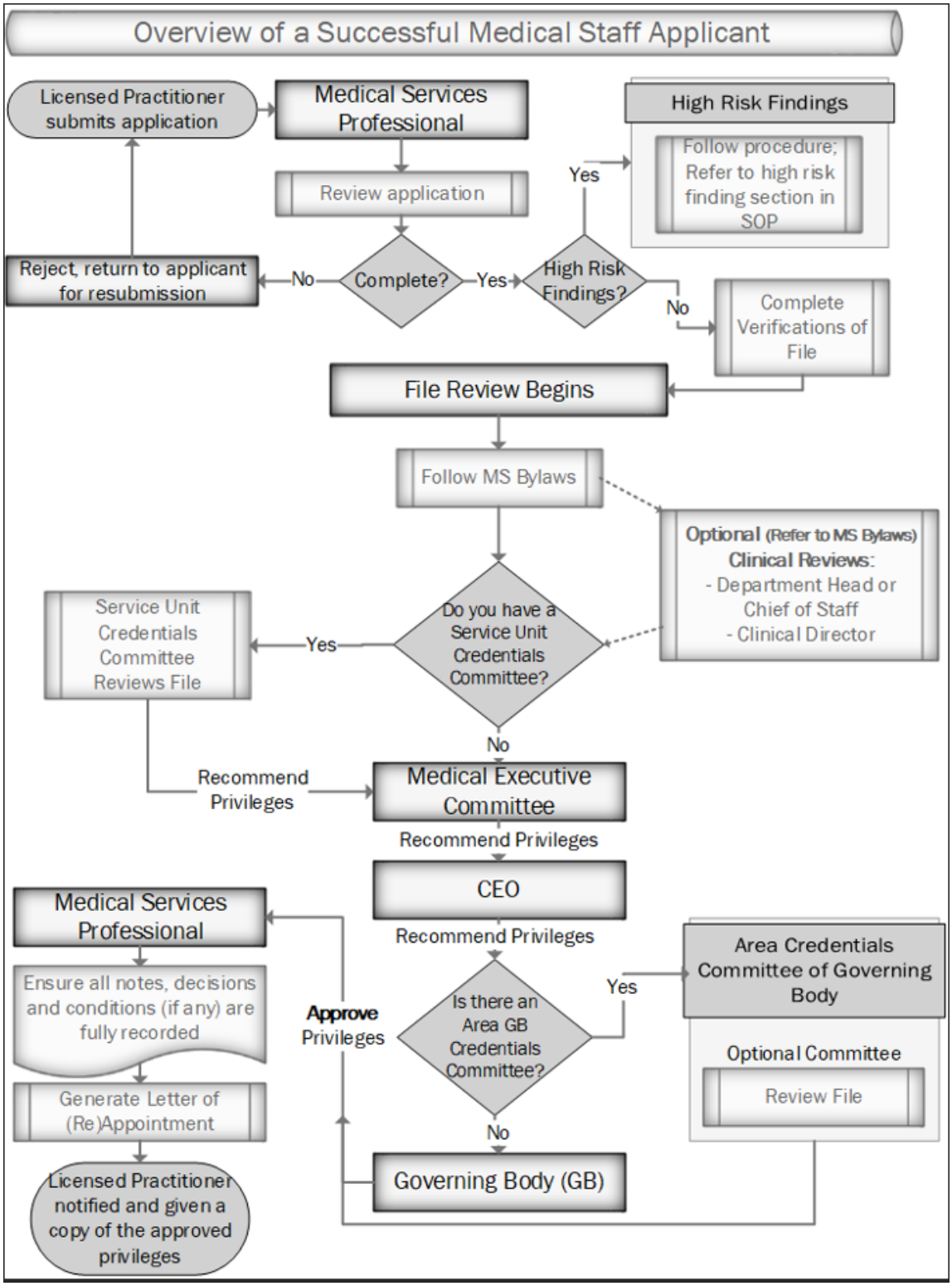
any IHS facility that a LP may apply to review their clinical and behavioral performance at that time. This summary is important as it ensures continuity and transparency in the credentialing process, supporting high standards of patient care. The document includes essential information such as the LP's details, employment dates, clinical competence, quality of care, professional conduct, and final recommendations. The form is completed by a peer or supervisor, as assigned by the clinical director.

Software – Exit Clinical Performance Summary
See Job Aid in the Appendix.

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



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



Section 6: Credentials Verification Processes

Credentialing and privileging processes are two primary MSP functions within the IHS. The credentialing process involves obtaining evidence of qualifications to verify that an applicant has the necessary experience, training, and authority to practice within the requested privileges. The following section identifies minimum requirements, instructions, and processes for credentialing applications, verifications, and appointments. Areas and service units may choose to have more stringent verification processes but not less stringent.

All LPs who provide patient care at IHS facilities must submit verifiable evidence of and maintain current, active, and unrestricted licensure, registration, certification, current competence, and/or credentials, and prove proficiency in their granted privileges following applicable law, accreditation standards, the IHM 3-1 Credentialing and Privileging policy, this SOP Manual, privilege criteria, and conditions of employment. The process for granting clinical privileges and/or medical staff membership is applied uniformly and objectively to all applicants. IHS areas and service units may choose to have more stringent credentialing processes than the SOP and IHM 3-1 Policy but may not have less stringent requirements.

SUBSECTION 1: 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. Primary source verifications received directly from the applicant cannot be used. If completing primary or DES verifications is impossible, such as when an educational institution or residency program has closed, secondary source verifications may be used. This process should only be used rarely and follow the facility's accrediting standards and policies. Please note that some accrediting bodies may not accept secondary sources. Copies of a diploma, license, registration, etc., in place of verifications are unacceptable. When a primary or designated equivalent source cannot be obtained, the applicant's recent affiliations should be contacted to discover how they obtained the verification. If an affiliation has a primary source verification of the credential, the applicant's signed release will be submitted to the affiliation, and a copy of the verification will be requested.

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.

SUBSECTION 2: GENERAL ADMINISTRATIVE VERIFICATION REQUIREMENTS

Credentialing verifications confirm that an applicant meets the minimum required licensure, current competency, character, training, education, and judgment to fulfill the position requirements and support any requested clinical privileges. This section communicates the general administrative requirements for credentialing verifications and processes for LPs applying for 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:
  - There must be a follow-up of any verification discrepancies found during the application and verification processes.
  - The practitioner can correct any information with a written and signed response and verified whenever possible. If necessary, the practitioner must follow up with the verifying entity to determine the reason for the discrepancy.
  - The burden of proof is on the applicant to provide all necessary verifiable information to support their application and to conduct required verifications.
  - The MSP will compare the CV/resume with the application and completed verifications and correct or resolve any discrepancies.
  - Ensure that all application and verification information in the software is correct, including the *From* and *To* dates for entries within the Education/Training, Hospitals, and Other References tabs.
- Shared MD-Staff Tabs:
  - The Hospitals, Education/Training, Other References, Peer References, Licenses/Credentials, Board Certifications, and Insurance tabs in MD-Staff are shared. This means that entry information within these tabs of an LP MD-Staff profile can be viewed by any other IHS facility listed in the LP's Appointment tab.
  - Any changes to these entries will change the entry for all facilities listed in the LP's Appointment tab. MD-Staff users should consider this when adjusting shared tabs for LPs appointed at multiple facilities.
- Duplicate entries:
  - If duplicate entries are found (Hospitals, Education/Training, Other References, Peer References, Licenses/Credentials, Board Certifications, and Insurance tabs), verify which entry is correct by comparing it to the verification and contact the other active affiliated sites to discuss deleting the duplicate entries, if the duplicate was due to another appointment.
  - Note that when verifications are manually or automatically added to an entry, a record of this verification is also automatically added to the Verification Log and will not be deleted if the entry is deleted from the designated tab. Suppose an entry from a tab that has a verification attached is deleted. In that case, the verification will NOT be deleted from the verification log.
- Purchase Card Holders:
  - MD-Staff users who are individual purchase card holders may use IHS-issued purchase cards within MD-Staff.

  - Use of IHS-issued individual purchase cards must comply with the IHS Credentialing and Program Government Purchase Card Use with the IHS CEP-MDS processes in the IHS Clinical Staff Credential and Privileging Guide (Appendix).
- Verification Attempts:
  - Verifications are attempted at least three times. Each attempt, including whom it was attempted to verify with, the date of request, verification methods, and any additional comments, is documented in the *Notes* section of the entry.
  - It may be necessary to contact the applicant to ensure the contact information is correct.
  - It is appropriate to request that the applicant contact the entity or individual to request that the verification be completed and returned.
  - If individuals or entities do not respond to verification requests, the LP may need to provide additional references.
  - Note that non-responsive individuals or entities may be a red flag.
- Expirable Alarms:
  - Each service unit/area must set alarms to monitor all credentialing and privileging expirables (e.g., appointments, licenses, registrations, certifications, board eligibility and certification, NPDB, and insurance) in the credentialing software.
  - Expirable credentials should have automated scheduled messages to alert LPs before credentials expire.
- Software Disruptions: During credentialing software disruptions, the service unit/area will maintain ongoing credentials verifications by completing primary source verification outside the credentialing software. Once the software becomes available, the information will be updated, and verifications will be uploaded to MD-Staff.
- Unfavorable Findings:
  - Unfavorable findings discovered during the credentialing process are reported to the appropriate medical staff and governing body leadership.
  - The IHM 3-1 requires that every person seeking membership and/or clinical privileges provide information and explanations on the MD-App credentialing application or separate from the application regarding (1) denials, restrictions, and resignations regarding previous or pending medical staff applications and/or clinical privileges; (2) reduction, suspension, revocation, voluntary or involuntary relinquishment, or non-renewal of clinical privileges; (3) current illegal use of drugs; (4) loss, suspension, restriction, denial of professional licensure or professional society membership, and; (5) convictions. These are addressed by the professional practice application questions, affiliation verifications, peer references, and through the Personnel Security Representative (PSR), Human Resources, and the acquisition contracting process of hiring.
  - In the event of negative comments received from verifications, maintain a record that thoroughly explains the context and reasons behind such remarks, ensuring the medical staff finds the explanation satisfactory. If necessary, the clinical director or equivalent may need to engage in follow-up discussions with the individual or entity to better understand the feedback provided.
- Checklists: MD-Staff allows for the use and customization of electronic checklists. Checklists ensure that credentialing verifications and standardized documentation are completed and accomplished correctly. The use of checklists is highly encouraged.

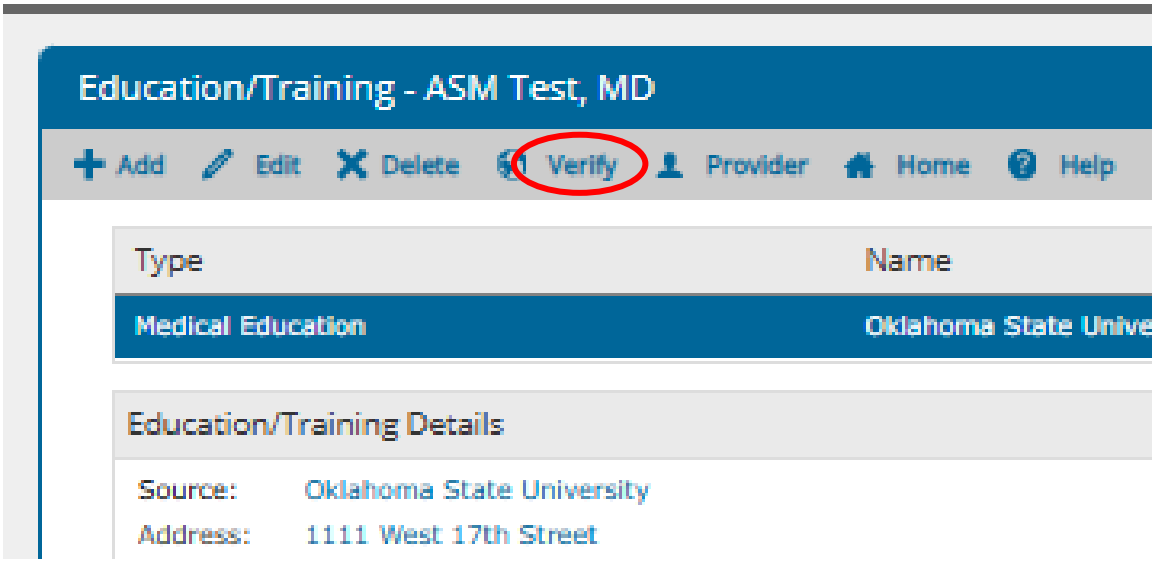
- MHT Capture: MHT capture for verifications is allowed. MHT capture allows verification of a credential on a website. Use the 'Save As' function to save a web page capture as an MHT file type. Note that MHT files cannot be viewed in Virtual Committee.

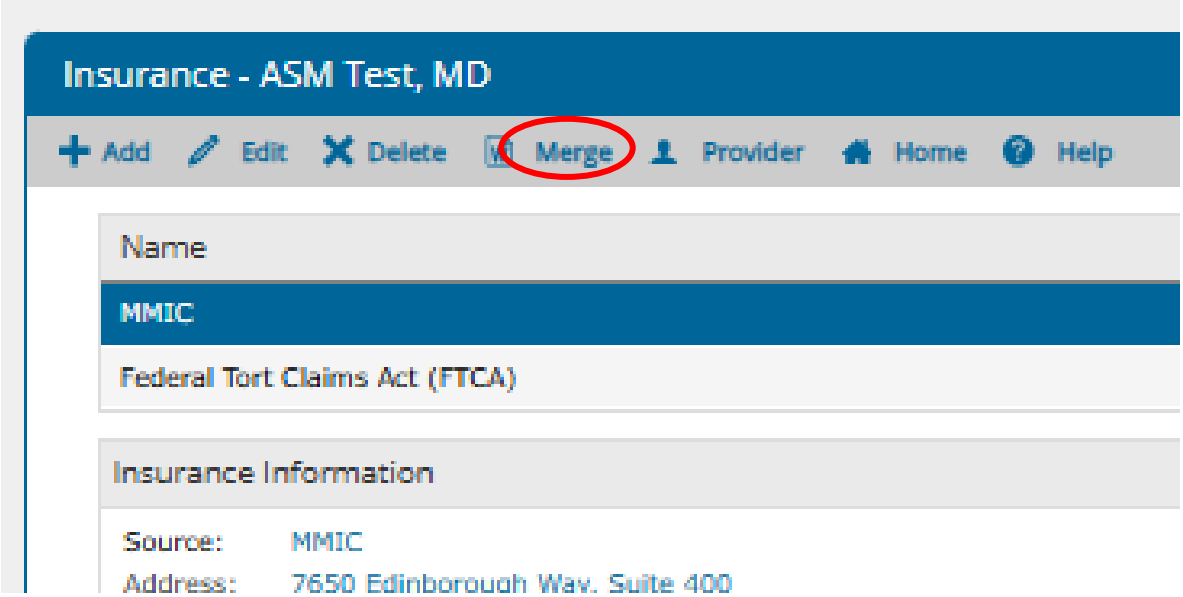
SUBSECTION 3: AUTOMATED AND MANUAL VERIFICATION DOCUMENTATION PROCESS

Automated or manual verifications must be attached to the entry in MD-Staff. Automated verifications are completed using the electronic automation features within MD-Staff. Manual verifications are completed with primary or designated equivalent sources outside MD-Staff instead of using the automated MD-Staff verification functions. Automated MD-Staff verification functions will be used whenever possible because they are more efficient than manual verification processes. Automation functions may require an initial setup. If users need assistance in setting up automated functions, contact the ASM.

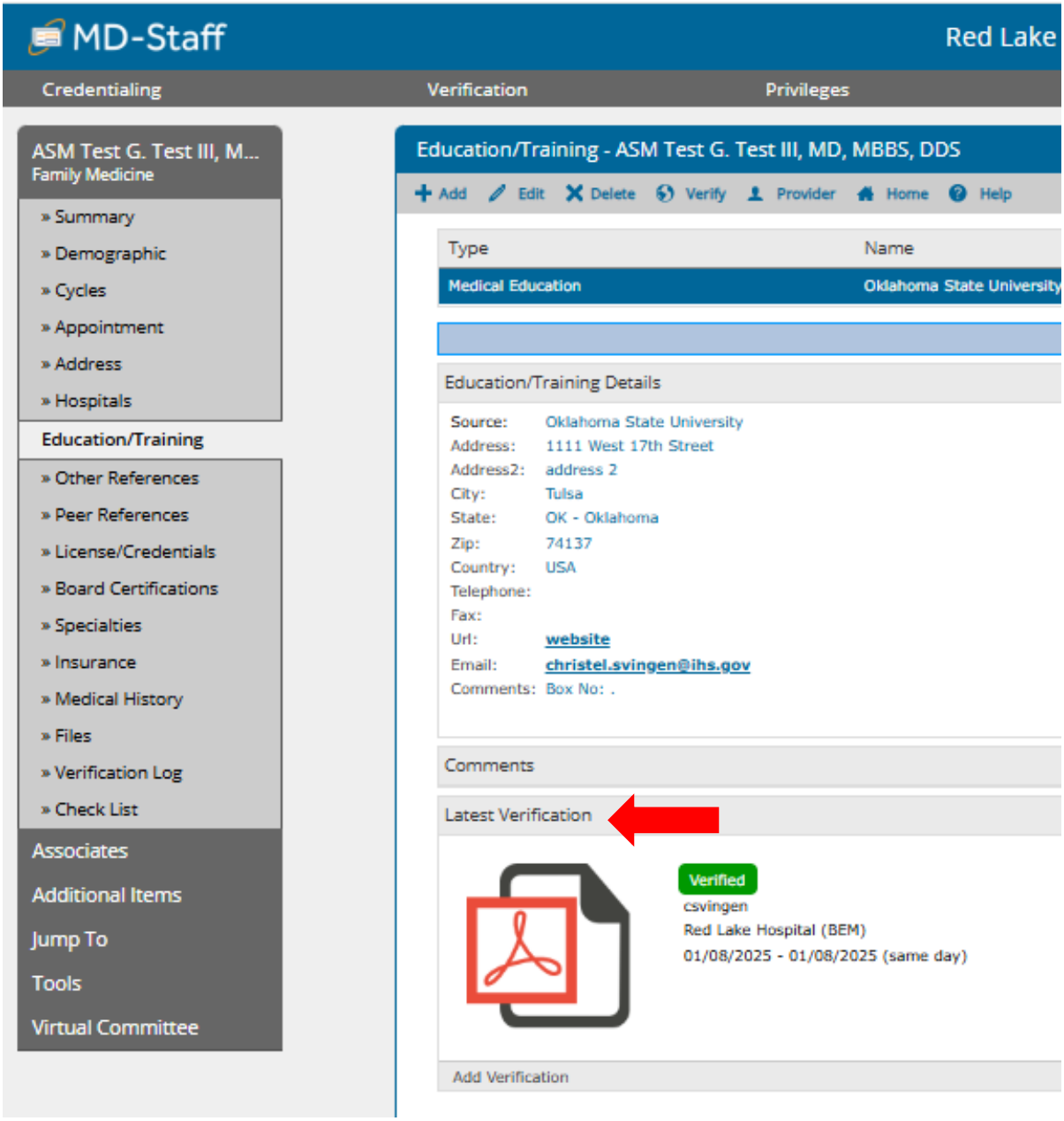
Automated MD-Staff Verification Functions:

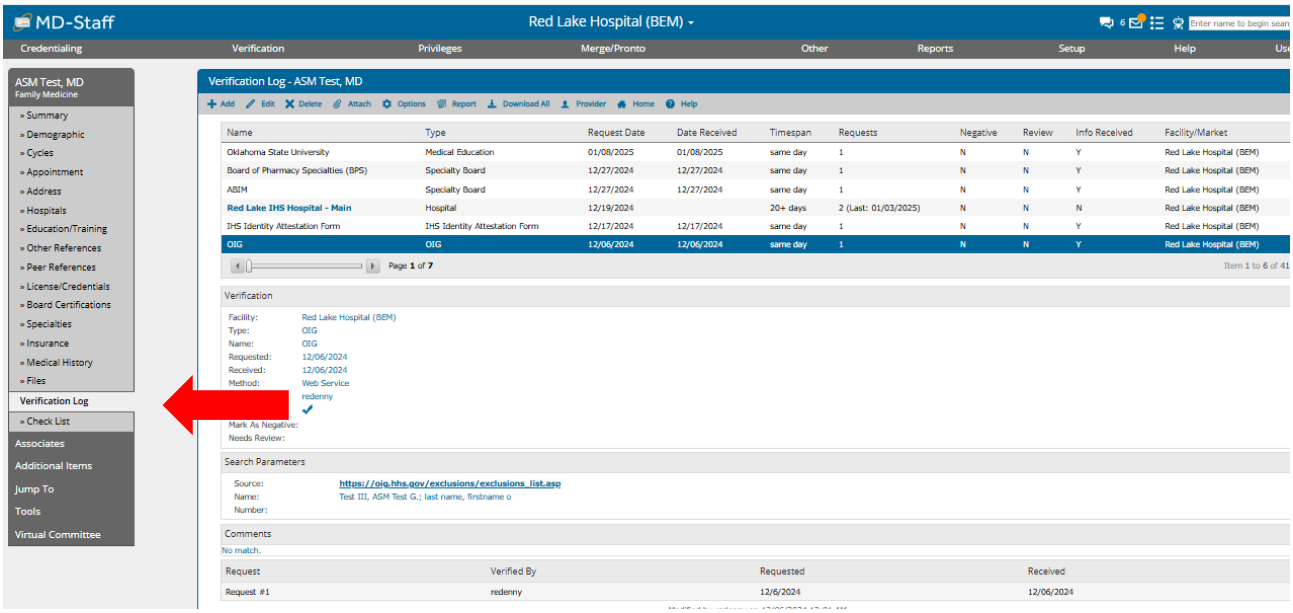
- Verify and Merge Functions in MD-Staff Tabs: Use the *Verify* or *Merge* functions within an entry to run automated verifications in the Hospitals, Education/Training, Other References, Peer References, License/Credentials, Board Certifications, and Insurance tabs.



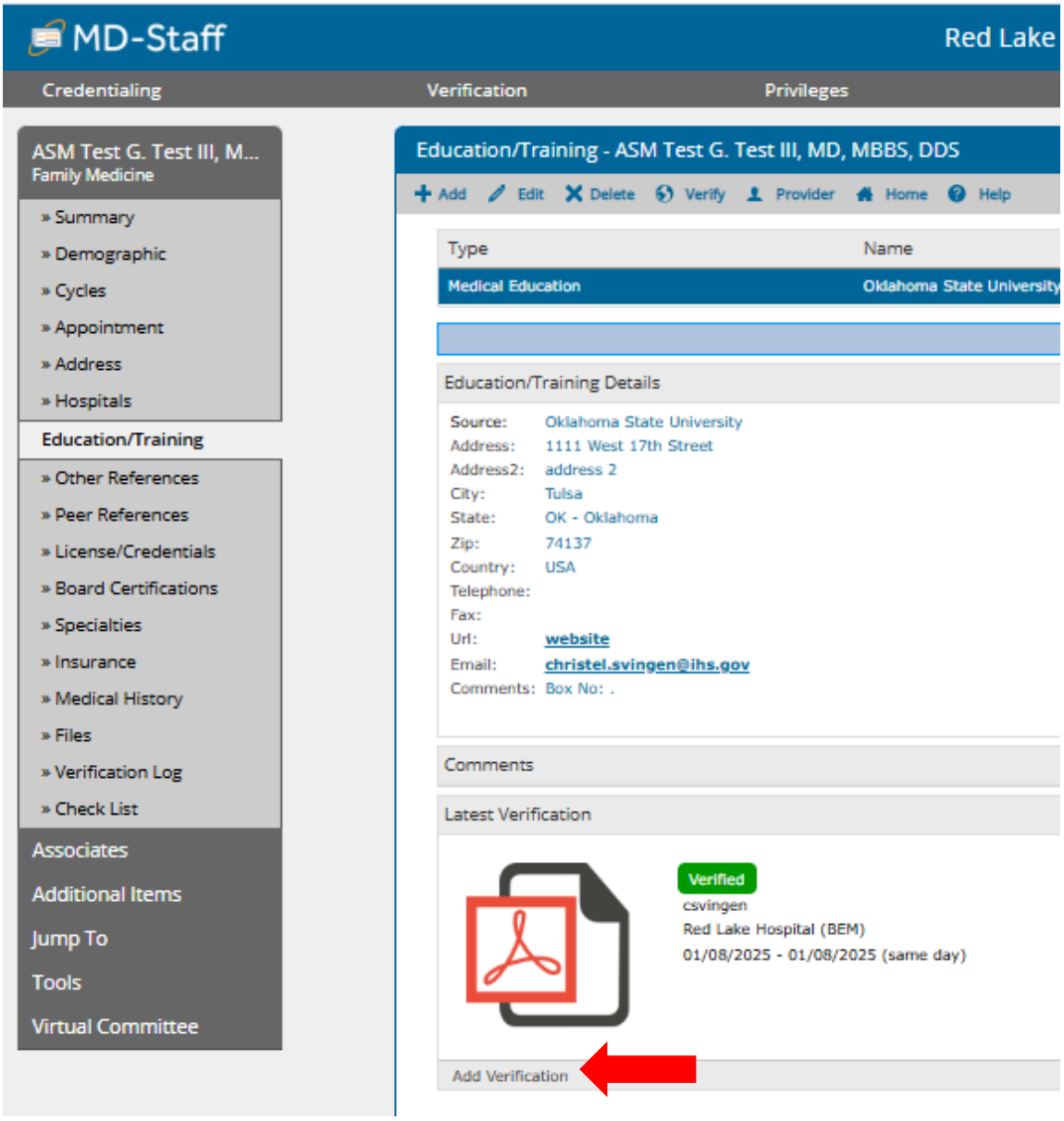


Once complete, the verification document and associated information will appear in the *Latest Verification* section of the entry and automatically be added to the Verification Log. This is important because credentialing compliance data for reports are extracted from the Verification Log. To complete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

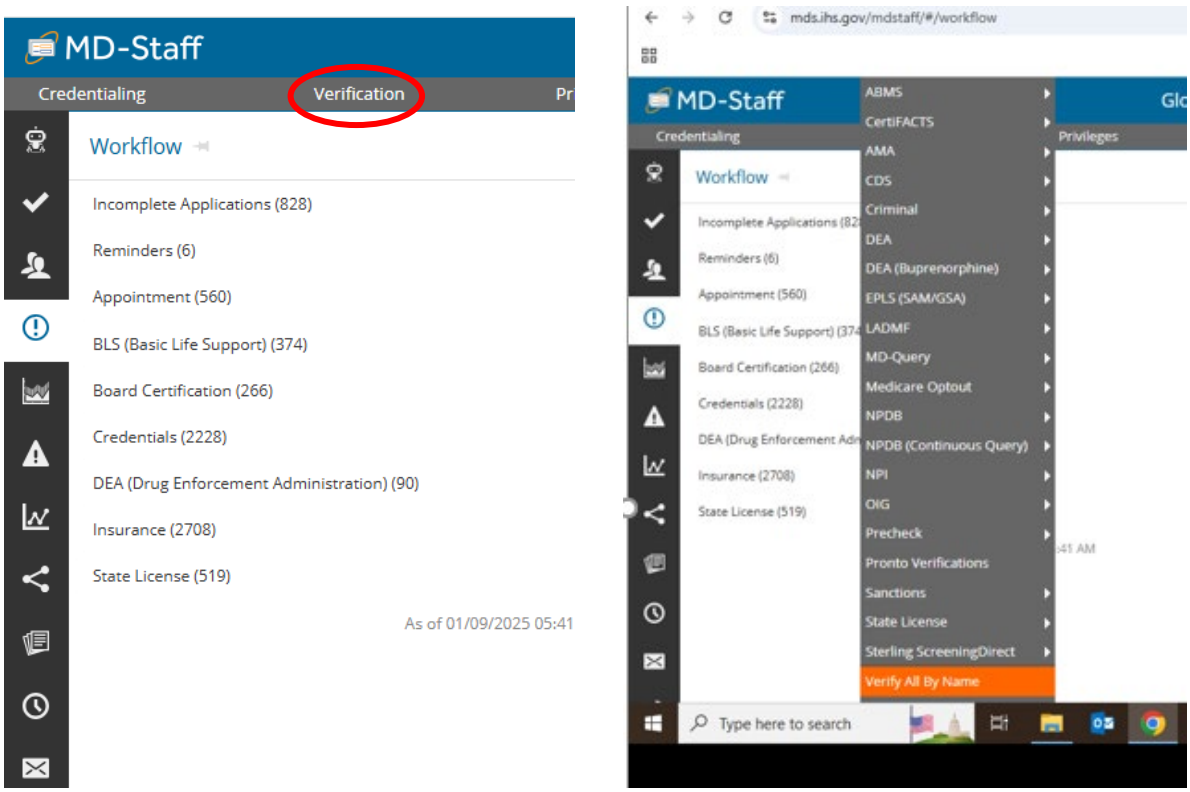

MD-Staff
Red Lake
Credentialing
Verification
Privileges
ASM Test G. Test III, M...
Family Medicine
» Summary
» Demographic
» Cycles
» Appointment
» Address
» Hospitals
Education/Training
» Other References
» Peer References
» License/Credentials
» Board Certifications
» Specialties
» Insurance
» Medical 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



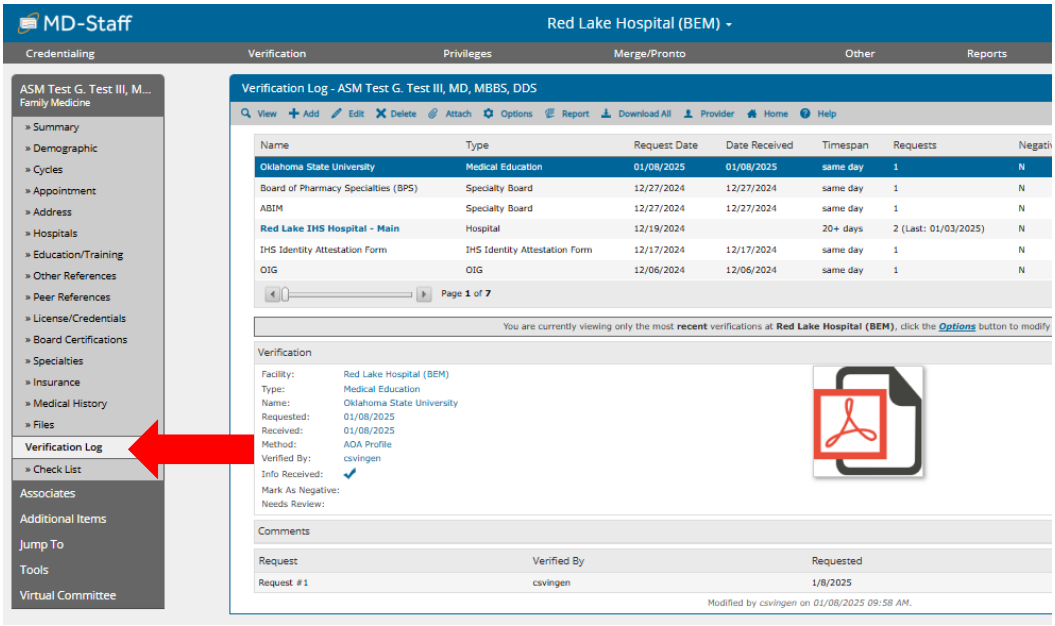
- <u>Add Verification Function in MD-Staff Tabs:</u> If MD-Staff automation for a specific verification is nonexistent or unavailable, a manual verification must be completed. Manual copies of verifications are documented by attaching them to entries in the MD-Staff provider profile (for the Hospitals, Education/Training, Other References, Peer References, License/Credentials, Board Certifications, and Insurance tabs.) Suppose a verification is completed manually outside of MD-Staff. In that case, the verification will be added to the entry using the *Add Verification* function. When this function is used, the verification will appear in the entry's *Latest Verification* section and the Verification Log tab. This is important because credentialing compliance data are extracted from the Verification Log for reports. Automated and manual verifications can be edited on the Verification Log tab. The *Add a 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*.



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

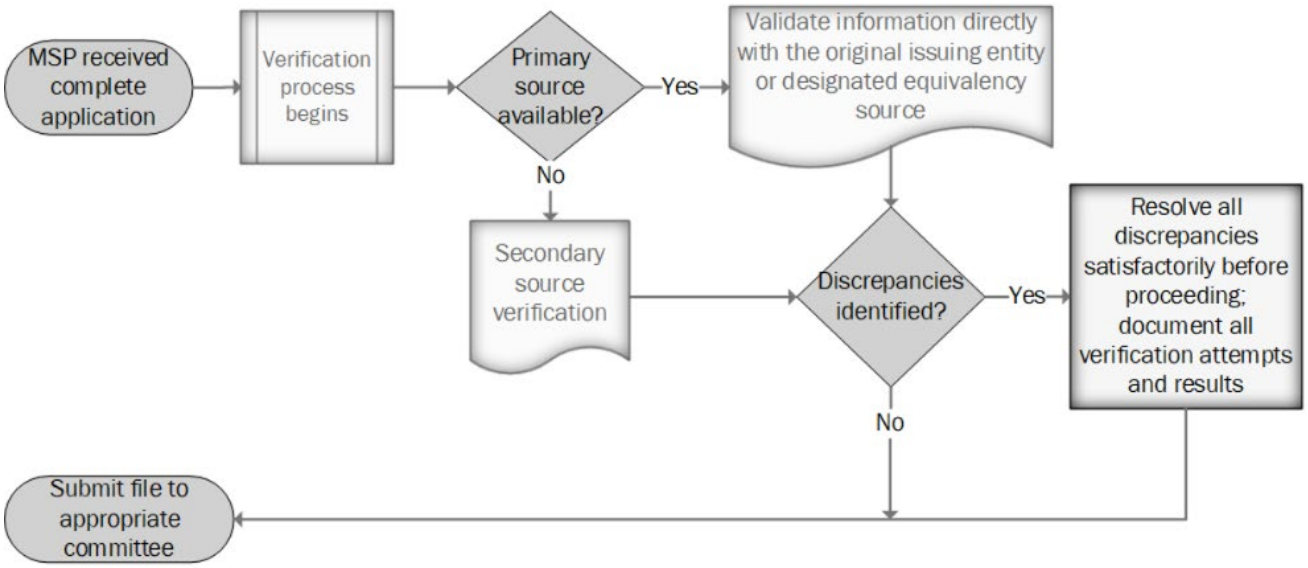


There are multiple ways to run automated verifications, including through the Verification section, upon importing an MD-App application or using the *Verify All* function found under *Tools*. MD-Staff automatically adds the verification information to the Verification Log when an automated verification 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*.



SUBSECTION 4: VERIFICATION PROCESS

The process map outlines the verification process:



The following verification process corresponds with the minimum requirements in the IHM 3-1.5 Medical Staff Credentials, Verification of Documentation. 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, along with the information in the above subsections:

1. <u>PROOF OF IDENTITY</u>

Verification Element – Proof of Identity

Verifying that the LP identified in credentialing documents is the same person presenting to provide patient care is essential. Some accrediting bodies require identity verification as a security measure because of multiple identity theft accounts and individuals posing as medical providers. The MSP, clinical director, chief of staff, or other designee can complete the verification.

Identification verification is the distant site's obligation for facilities that execute the credentialing by proxy (CBP) method for telehealth LPs. The agency's CBP agreement may delineate identification verification responsibilities.

A recent photograph of the LP will be obtained and uploaded to the LP file in the Demographic tab. This is important for E>Priv and Virtual Committee so that 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

A state-issued driver's license, passport, military ID, or other state or government photo identification that has not expired is acceptable proof of identity. The identification verification will be presented in person or by telecommunication video with audio. Documentation of the verification will be completed on the IHS ID Attestation Form. Copies of identification submitted without in-person or telecommunication video with audio are unacceptable.

Software – Proof of Identity

- Upload the IHS ID Attestation Form to the LP's Verification Log as "IHS ID Attestation Form:"
  - Received Field: the date the ID is verified.
  - Method: "ID – in person" if the individual's identity is verified in person. Identity verifications may be completed via an audio and video telecommunications link. In this case, the Method is "Telecommunication Video w/Audio." Identification attestations should not be shared among facilities unless the area has a formalized centralized credentialing office.
- To prevent identity theft, copies of the LP's state-issued driver's license, passport, military ID, or other state or government photo identification should not be kept in the credentialing software.

2. PROFESSIONAL EDUCATION AND POST-GRADUATE TRAINING

Verification Element – Professional Education and Post-Graduate Training

LPs must possess a valid diploma certifying them as graduates of a professional school accredited by a nationally recognized accrediting body appropriate to their professional discipline. It is important to note that obtaining a degree and postgraduate training does not automatically 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 has received a medical degree or qualification from a foreign medical school. The location of the foreign medical school, not the citizenship of the physician, determines whether the graduate is an IMG. This means that U.S. citizens who graduated from foreign medical schools abroad are considered IMGs and would require ECFMG certification. Non-U.S. citizens who graduated from U.S. or Puerto Rico medical schools are not considered IMGs and would not require an ECFMG certification. Canadian medical school graduates who graduate on or after July 1, 2025, are considered IMGs and, therefore, must obtain an ECFMG certification. Certification by ECFMG is the standard for evaluating the equivalence of educational

qualifications of these physicians before they enter U.S. graduate medical education. ECFMG certification is required to obtain an unrestricted medical license in most U.S. states.

Providers with Fifth Pathway certificates who apply for an initial appointment will be referred to the Agency Clinical Credentials Committee (ACCC) for an endorsement determination, then considered by the governing body.

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, or other organized professional training will be verified. A qualifying degree is the degree required for the applicant's position and privileges.
- At reappointment, any new education or post-graduate training completed since the last appointment must be verified 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: If a verification request is sent directly to the school or training facility, the OMB-approved IHS Education Training Verification Pronto or Form must be used. However, schools or training facilities may respond to verification requests by providing a facility-specific verification document instead of completing the pronto or form. This is acceptable if the document includes all required information on the OMB-approved IHS Education Training Verification.
- 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., as long as the source is a designated equivalent source for education and training verifications.

Software – Professional Education and Post-Graduate Training

- LPs submit, on the MD-App credentialing application, a complete list of all domestic and foreign institutions and colleges where education and post-graduate training was received, even if it is incomplete. Education and post-graduate training entries in MD-Staff include the facility name, location, dates of attendance, degree information, and completion status. Any voluntary and involuntary withdrawals, leaves of absence, and disciplinary actions (suspension, expulsion, dismissal, probation, etc.) must be disclosed and explained.
- Education and post-graduate training verification documents are attached to the associated 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.
- 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.

3. EXPERIENCE (HOSPITALS AND OTHER REFERENCES)

Verification Element – Experience (Hospitals/Other References)

Experience must be assessed to assist in establishing current competency. Experience and practice history information disclosed by the LP versus those listed on their CV/resume and the primary source or DES verifications are compared and reconciled. If discrepancies exist, the applicant must provide a written explanation or be offered the opportunity to amend the submitted application. Reconciliation of practice history timelines may lead to additional affiliations and employment history verifications. The LP will explain any gaps over 30 days since graduating with their qualifying degree (see Time Gaps.) The following are the types of experience listed in either 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, relevant experience (affiliations, work history, and military) for at least the most recent five years for work history and the most recent five years for affiliation history—or as far back as necessary per any conflicting information or suspicious indicators—to assess current competency is verified.
- 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:
  - If a verification request is sent directly to facilities for affiliation or other work history verifications, the OMB-approved IHS Affiliation Verification Pronto or Form must be used.
  - Work history, affiliation, and active military service verification requests may be returned from employment sources without answering all the questions on the OMB-approved IHS Affiliation Verification Pronto or Form because they are irrelevant to the position, e.g., privileges or medical staff. This is acceptable.
- Affiliation letter from the facility or designated verification website (affiliations where the LP was credentialed and privileged):
  - Facilities may respond to verification requests by providing a facility-specific verification document, such as an affiliation letter, instead of completing the pronto or form. IHS service units or areas must determine if this documentation allows for the appropriate assessment of the LP's experience. Service units may request more information about the provider's competency, behavior, and status. The OMB-approved IHS Affiliation Verification Pronto or Form must be used in this case.
  - 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 that contains employment history for verification inquiries. If this is the required route for obtaining employment history verifications for an organization and staff are instructed not to provide information for employment history verifications, then this type of 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 30 or more days when the LP is not in school or training, in the military, teaching, working, or volunteering, starting when the LP graduated from medical/professional school. Explanations of these gaps, or lack thereof, may provide insight into an applicant's past that may be critical to the credentialing decisions. IHS understands applicants may report gaps due to disability, pregnancy, raising children, caring for parents, etc. If gaps are discovered but the LP does not submit any gaps or explanations on the application, compare the application with the CV/resume to ensure nothing is missing.

The credentialing software allows users to run a Gap Report to assist in identifying gaps. However, service units or areas may develop their own methods for assessing gaps.

Standard Work Element – Time Gaps

- At the initial appointment, any time gaps over 30 days since graduation from medical/professional school will be documented and explained on the initial application.

Acceptable Verifications – Time Gaps

Verification of time gaps is not required, but an explanation is.

Software – Time Gaps

- LPs submit and explain any periods or gaps longer than thirty (30) days since graduation from professional school during which the applicant was not in school or training, in the military, teaching, working, or volunteering on the application. If the application is found to have any unexplained time period or gaps, the application will not be processed and will be returned to the applicant 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*

- Ensure that the From and To dates for entries within the Hospitals, Education/Training, and Other References match verifications to ensure that the information is accurate and to assess time gaps appropriately through 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 check the facility's privilege criteria and conditions of employment (for IHS employees, review the position description, and for contractors, review the contract) to determine if the LP meets the board-certified/board-eligible requirements. Any identified discrepancies will be communicated to the facility's clinical leadership. The facility's clinical leadership is responsible for ensuring that the LP's board-certified or board eligibility aligns with the requested privileges.

Licensed Practitioners who are licensed MDs or DOs and provide care in the IHS must be board-eligible (BE), board-certified (BC), or exempt. Exempt means LPs were appointed in the IHS before **10/01/2026** and are in and remain in good standing, as noted on ongoing peer review and any Exit Clinical Performance Summary (ECPS). "Board Eligible" is defined as the time before the initial certification in a specialty or subspecialty, typically ranging from 3-7 years, depending on the member board requirement. Advanced practice registered nurses (APRN) and physician assistants are required to hold board certification and maintain that certification throughout their employment with the IHS. Additional information can be found in the Indian Health Manual, chapter 4 and chapter 28.

Standard Work Element – Board Certification
- Board Certification:
  - Beginning 10/01/2026, medical doctors (MD) and doctors of osteopathy (DO) will be board-certified or board-eligible. Any MD or DO hired before 10/01/2026 and not board-certified will be considered exempt from obtaining board certification.
  - At the initial appointment, all active and inactive board certifications are verified.
  - At reappointment, board certification verification is not required unless it coincides with the certification's expiration date.
  - Board certifications will be verified before expiration.
  - Professional affiliations and medical society memberships are not required to be verified.

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), etc. as long as the source is a designated equivalent source for board certification verifications.

Software – Board Certification

- LPs submit a complete list of active and inactive board certifications, including board name, certification number, original dates, recertification dates, and participation in the maintenance of certification, if applicable, on the MD-App credentialing application. LPs must disclose and explain any instances of discipline, suspension, probation, or reprimand.
- For active board certifications that expire or become inactive, the Status will be changed to Inactive or Expired, and the *In Use* box will be unchecked.
- All active and inactive board certifications are documented in the Board Certifications tab. Note: this does NOT include state licenses to practice; these are documented in the "License/Credentials" section:
  - 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, or the recommended date of renewal.
  - 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

Every licensed practitioner who provides patient care in federal facilities must possess a current, active, full, and unrestricted license or registration from a State, the District of Columbia, the Commonwealth of Puerto Rico, or a territory of the United States. Licenses allow providers to practice within the scope of each license held. However, the facility can restrict this scope. Surrendered licenses or license sanctions, restrictions, revocations, suspensions, reprimands, or probations will be investigated with the licensing entity and the NPDB.

Standard Work Element – Licensure

- At the initial appointment, all active and inactive professional medical licenses will be verified.
- At reappointment and when new privileges are requested, all active licenses will be verified.
- Licenses will be verified before expiration.

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 submit a complete list of all active and inactive professional licenses and registrations, including the issuing state, license type, and license number on the MD-App credentialing application. LPs must disclose and explain any instances of 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 instructions on how to complete an automated or manual verification. See Subsection 2 for information about 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 registrations, DPS, and CDS registrations and certifications will be verified, as well as inactive registrations and certifications if verification is available.
- At reappointment, all active DEA registrations, DPS, and CDS certifications will be verified.
- DEA registrations, DPS, and CDS certifications will be 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 submit a complete list of all active and inactive DEA registrations, DPS, and CDS certifications, including the issuing state, license type, and number. LPs must disclose and explain any instances of discipline, suspension, probation, or reprimand.
- All active and inactive DEA registrations, DPS, and CDS 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 registrations, DPS, and CDS certifications that become inactive, the *Type* will be changed to *Inactive DEA* or *Inactive CDS*, and 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.

8. CURRENT COMPETENCY

Verification Element – Current Competency

All LPs who provide patient care at IHS facilities must provide verifiable evidence of and maintain current competence. Current competency may be documented through multiple sources identified in this SOP, such as education, training, affiliations, peer references, and licensure. These verifications ensure a comprehensive assessment of the LP's proficiency.

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 involves obtaining assessments, references, and evaluations from all sources with firsthand knowledge of the applicant 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 evaluates performance in specific practice areas to ensure that the LP meets the required standards of care.

Software – Current Competency

Current competency is documented in multiple locations in the software.

9. IHS CONDITIONS OF APPLICATION AND RELEASE

Verification Element – IHS Conditions of Application and Release

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

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.
- 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.

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

Verification Element – CME or CPE

Documentation of the LP's CME, CPE, or equivalent continuing education is required to assess current competency. Beyond collecting continuing education at the initial and reappointment, it may be collected at any time specified by local medical staff bylaws or accrediting body requirements. Local

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

Standard Work Element – CME or CPE

- At the initial appointment, continuing education for the previous two years is collected unless the LP has completed post-graduate training in the last two years.
- For reappointment, continuing education completed since the last appointment is collected.

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. These documents are filed in the Files tab as Continuing Education.
- Facilities may choose to track the IHS Essential Training on Pain and Addiction in MD-Staff. The information and certificate are stored in the License/Credentials tab of MD-Staff. If the applicant does not meet the requirement to complete the training, the word Exempt can be added to the License Number field for the IHS Essential Training on Pain and Addiction.

11. PROFESSIONAL PEER REFERENCES

Verification Element – Professional Peer References

Professional peer references provide information regarding the LP's medical and clinical knowledge, interpersonal skills, technical skills, clinical judgment, communication skills, ability, and professionalism (ACGME Six Core Competencies).

- The facility will follow its accrediting body's definition of a peer. Without a peer definition, the IHS definition of a peer includes a practitioner in the same clinical discipline.
- All peer references are from a professional authority who has worked directly with the applicant within the past two years and can authoritatively speak to the applicant's character, clinical experience, and competency.
- The peer must be familiar with the individual's performance to provide a recommendation. This could be someone within the same organization, a different service unit, or someone outside the organization.
- It is highly recommended that applicants who have recently graduated from training programs obtain one reference from the training program director, department chair, or chief of staff.
- A peer must not be a relative, spouse, or partner.
- For facilities with difficulty complying with the definition of a discipline-specific peer, identifying another LP in IHS with similar credentials is recommended to conduct chart reviews and then complete the peer reference. However, peer references are often used at reappointment to help establish an LP's current competency to support the peer review process.

Standard Work Element – Professional Peer References

- IHS policy requires the collection of at least two peer references at the 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, the facility must follow its accrediting body, medical staff bylaws, or area/service unit policies for the number of peer references required at reappointment.

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: CMO/CD and other LPs in leadership roles who are credentialed and privileged through the software and have MD-Staff CMO/CD access should not have their completed Peer Reference forms attached from their Files to their Peer Reference Tab. This ensures that the LPs providing the peer references are protected and remain confidential.
- 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.

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 was developed due to legislation enacted by the U.S. Congress. NPDB reports contain information reported by 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. It is a crucial resource for verifying healthcare LPs' credentials and disciplinary history.

- Initial Appointment/Reappointment: Each LP will have an NPDB query reviewed as part of their initial review for appointment. Once an LP is appointed to the medical staff or approved for clinical privileges, they are enrolled in the NPDB CQ. The NPDB CQ is more effective than a one-time query because it provides ongoing monitoring of healthcare practitioners and notifies participating organizations within 24 hours of receiving a report concerning an LP. The NPDB CQ enrollment notifies the organization that enrolled the LP by email of any new or updated reports.
- Resignation/Termination: When an LP resigns or terminates his/her medical staff membership and/or privileges, the LP's CQ enrollment is canceled, as required under Federal Regulations.
- Receiving Reports: The following outlines the steps to take when the NPDB sends a new or updated report with findings or comments:

  - The NPDB will email the facility's databank administrators when an LP is enrolled in NPDB CQ and a new or updated report is filed on the LP account.
  - The NPDB Databank Administrator will access the NPDB website, obtain the new or updated information report, and notify the CD of the NPDB report. The report may be sent through Secure Data Transfer but not through regular email.
  - The NPDB Databank Administrator should continue to notify the CD as soon as possible of any new or updated reports received.
  - Clinical leadership is responsible for the next steps documented in the MEC minutes.
- Filing NPDB Reports: The MSP should become familiar with the NPDB Guidebook, including the Reporting Requirements, to guide clinical leadership regarding reporting requirements. The NPDB Customer Service Center (1-800-767-6732) is available to assist with guiding reporting requirements. The Area OGC attorneys should also be consulted. Additional guidance is provided for internal reporting notification by the Agency Clinical Credentials Committee (ACCC).
- NPDB Administrators: At least two employees at each service unit should be designated as NPDB administrators to ensure timely notification of receipt of reports. The NPDB reporting requirements, OIG/LEIE, Medicaid/Medicare, and other Federal programs report exclusions monthly.

Standard Work Element – NPDB

- An NPDB query will be completed for all LPs at initial application (or at pre-screen if the facility is completing pre-screens), at reappointment, and when the provider requests new privileges. All NPDB query reports will be uploaded into the credentialing software (See Software below.)
- Once the LP's medical staff appointment and/or privileges are approved, the LP is enrolled in an NPDB Continuous Query (CQ).

Acceptable Verifications – NPDB

The NPDB query report. The report should indicate the name of the facility requesting the report. If the area is set up for formalized centralized credentialing, the area should contact the NPDB to ensure it meets all requirements for proper setup.

Software – NPDB

- NPDB query reports, unless run through the software, are manually uploaded in the Verification Log of the LP's record in the manner 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) is a standard certification for those working in healthcare settings, ensuring proficiency in life-saving techniques. LPs who work onsite at IHS facilities must minimally obtain and maintain BLS certification. If an LP holds life support certifications considered more advanced than BLS (for example, ACLS), the LP does not need to maintain a BLS certification. Life support certifications are not required for telemedicine LPs or any other LP who does not work onsite. Additional life support certificates may be required through privilege criteria or area/facility bylaws and policies. Ensure the certificate type matches the agency/facility policy requirements and clinical privilege criteria for which the LP applies.

Standard Work Element – Life Support Certificates

- BLS, or a more advanced life support certification, is required for all LPs who work onsite at IHS facilities.
- At the initial appointment, a copy of all active life support certifications must be obtained.
- Updated copies of life support certifications are obtained before expiration.

Acceptable Verifications – Life Support Certificates

Copies of life support certifications are acceptable. Life support certifications do not need to be primary source verified.

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.
- For active life support certifications that the LP does not renew and becomes inactive, the *Type* will be changed to *Inactive Life Support,* and the *In Use* box unchecked.
- 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 Centers for Disease Control and Prevention (CDC) recommends routine vaccinations for clinicians and other healthcare providers. Immunization records in IHS are maintained by the employee health staff, infection control staff, and/or other staff trained in collecting, analyzing, and complying with required immunizations at IHS facilities. Collecting immunizations through the medical staff credentialing process is not a required credentialing verification element. Waiting for a provider to submit immunization records should not hold up processing a credentialing application. Immunization information is a category of record covered in the IHS Credentialing System of Records. Immunizations are not required for telemedicine LPs or any other LP who does not work onsite.

Standard Work Element – Immunizations

- MMR, PPD, and Hep B immunization information is obtained from the LP. However, the receipt of documentation of immunization information and records should not hold up the credentialing file approval process.
- At reappointments, immunizations are not collected.

Acceptable Verifications – Immunizations

Copies of the immunization record are acceptable. Immunization records are not primary source verified.

Software – Immunizations

- LPs are requested to complete the application's Health Screen/Immunization section and submit a copy of their immunization records.
- Immunization information provided on the application is imported to the Medical History tab in MD-Staff, and immunization records are uploaded to the Files tab.
- The employee health nurse and/or infection control staff may be provided with documentation of immunization records received. This can be accomplished through an E>Priv Display.

15. CURRENT LIABILITY INSURANCE

Verification Element – Current Liability Insurance

Credentialing files include documentation of current professional medical malpractice liability 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.

The Federal Tort Claims Act (FTCA) provides tort coverage, e.g., medical malpractice coverage, to federal employees, certain federal contractors and volunteers, and Indian Self-Determination and Education Assistance Act contractors. Therefore, neither the federal government nor ISDEAA contractors must purchase private malpractice insurance (or other insurance) to cover their actions when acting within the scope of their official duties. Questions regarding FTCA coverage should be raised to the HHS Office of the General Counsel.

Standard Work Element – Current Liability Insurance

- For contractors that do not qualify for FTCA, an acceptable verification (see below Acceptable Verifications section) for all currently active liability insurance coverage will be obtained at the initial appointment and before liability insurance coverage expiration.
- For IHS employees, the IHS does not require LPs to hold current professional liability coverage.

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 COI from the malpractice carrier or contracting agency.
  - A verification letter from the malpractice carrier.
- The certificate of insurance (COI) or verification letter includes 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 gathered on professional liability claims, suits, and/or judgments helps assess an LP’s history of malpractice claims and identify patterns of professional liability claims to gauge their professional

liability and risk profile. These verifications help ensure that practitioners meet the high standards expected in healthcare settings, protecting patients and the integrity of the IHS facility. It is prudent to remember that there is a higher rate of malpractice suits filed in some physician specialties, such as obstetrics, orthopedics, and neurosurgery. In addition, liability insurance providers may settle some lawsuits because it's less expensive than litigation.

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

- At the initial appointment and reappointment, documents listed as acceptable verifications (See below 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 (displayed in *Additional Items -> Incidents/Claims* in MD-Staff.)
- 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 integral to the credentialing process at IHS facilities to ensure that LPs meet all regulatory and ethical standards. Excluded providers have adverse action taken, such as revocation, probation, civil complaint, etc. Reported on a sanctions list may be considered an adverse credentialing finding. The Credentialing Committee, CD, and CMO must

immediately review any sanctions or exclusions identified. These checks are performed across various databases.

- **Office of Inspector General (OIG)/List of Excluded Individuals and Entities (LEIE):** The OIG/LEIE maintains and provides monthly updates for practitioners currently barred from participating in CMS and/or other federal healthcare programs due to fraud or misconduct. Checking the OIG/LEIE website ensures that healthcare facilities do not employ individuals who might compromise patient safety and/or IHS compliance with federal regulations.
- **Excluded Parties List System (EPLS) - System for Award Management (SAM/GSA):** Formerly GSA/EPLS (General Services Administration/Excluded Parties List System), SAM monitors federal agency debarments, including those from the OIG and other state-required sanction queries. SAM is a federal database that consolidates information on entities, including healthcare providers, prohibited from receiving federal contracts or grants. Checking SAM ensures that LPs are in good standing and eligible to participate in federal healthcare programs, safeguarding the integrity and compliance of IHS facilities.
- **Federation of State Medical Boards (FSMB):** The FSMB is a comprehensive primary source data repository for all state licenses, disciplinary sanctions, closed residency programs, and medical staff affiliation. The FSMB can be used as a designated equivalent source that lists all LP active and inactive state licenses and provides reports for closed residency programs. FSMB is a paid verification that is encouraged but not required. The facility may choose instead to use primary source verification by contacting each state medical board individually.
- **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):** The health status of LPs is assessed through attestation questions on the credentialing applications. As an important reminder, the LP completes these questions and the credentialing application after offering employment or awarding a contract. LPs must answer questions on the credentialing application form regarding their current health status for IHS to determine their ability to practice their profession with reasonable skill and safety. All requests for reasonable accommodation are the responsibility of the reasonable accommodation coordinator at the Area or HQ.
- **National Provider Identifier (NPI):** The NPI is a unique number assigned to LPs through the Centers for Medicare and Medicaid Services (CMS) National Plan and Provider Enumeration System (NPPES.) The Health Insurance Portability and Accountability Act (HIPAA) requires the NPI for administrative and financial transactions. An LP without an NPI number cannot bill or be reimbursed for patient care services.
- **Internet Search:** Performing an internet search on an LP can uncover additional information not found in traditional credentialing sources, such as news articles, social media profiles, and public records, which may reveal relevant professional or personal conduct issues. This step helps ensure a comprehensive provider evaluation and supports 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 application.
- **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 misconduct, or other relevant issues. Add the internet search information in the Verification Log (see below instructions.)

Acceptable Verifications – Sanctions Disclosure or Current Investigations

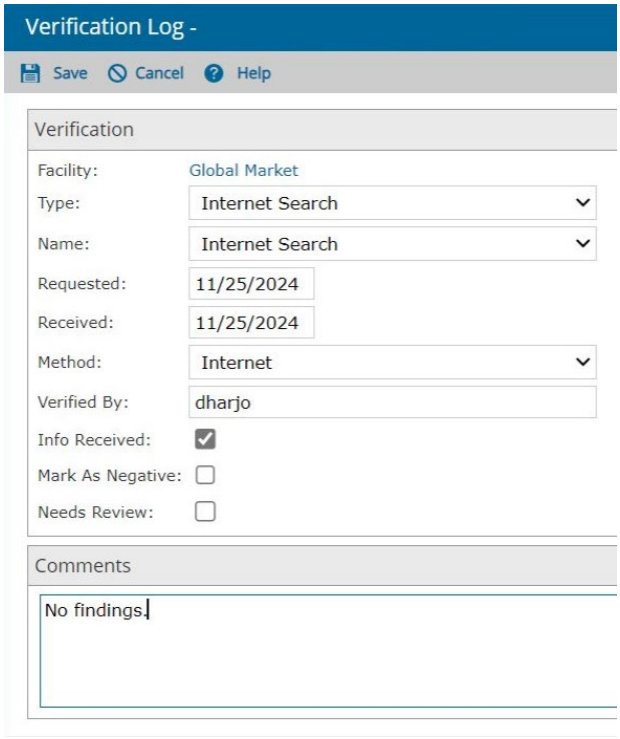
- **OIG/LEIE:** OIG report or NPDB query report.
- **SAM/GSA:** EPLS (SAM/GSA) report.
- **FSMB:** See Item (6) Licensure above.
- **CMS State-Specific Opt-Out:** The NPDB or the Medicare opt-out verifications can be completed electronically in MD-Staff.
- **Ability to Perform (Health Status):** Completed 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

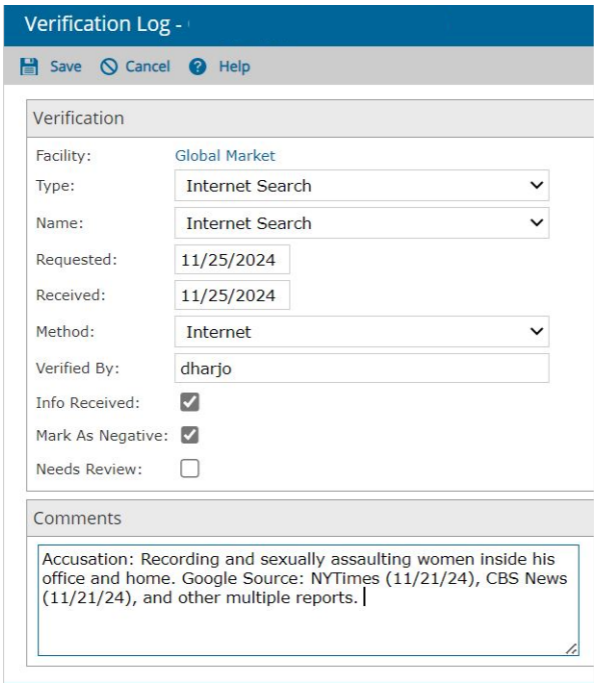
- **OIG/LEIE, SAM/GSA, CMS State-Specific Opt-Out, NPDB Query Report, and NPI:** These verifications are housed in the Verifications Log. There are multiple ways to run these verifications through MD-Staff. The verification information is automatically added to the Verification Log when processed:
  - When importing an MD-App application, the report will be generated and added to the Verification tab if the *Verify All* checkbox is checked.
  - 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
- **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 negative or concerning findings are discovered in the internet search, a summary of the findings will be added to the *Comments* section, noting the sources and dates of information. Screenshots of relevant web pages with findings will be saved and attached to the LP's Verification Log. If any concerning information is found, notify the credentialing committee and/or the clinical director as soon as possible.



- **State-Specific Sanctions Verifications in MD-Staff:** MD-Staff allows for verification of state-specific sanctions.
  - To activate/deactivate the states included in sanctions verifications, navigate to Setup -> Web Services -> Sanction Settings. Note that IHS recommends activating all Sanctions sites. Any state with *False* under the *Enable* column is not activated. To activate it, click on it and then click Activate. To run a verification, navigate to Verification -> Sanctions and select Verify by Name, Verify by Filter (to verify multiple providers), or Verify All. Verify All runs the verification for all providers who are not archived.

Section 7: Credentialing High Risk Findings and Management

The LP's medical staff applications, forms, and tools will be reviewed to identify any high-risk findings. If any high-risk findings are present, the CD is alerted, and the file must be presented to the Agency Clinical Credentials Committee (ACCC) for an endorsement determination, then considered by the Governing Body. A request for an endorsement from the ACCC may only be submitted if the MEC and GB concur that an endorsement is warranted. The IHS Headquarters ACCC will review the determination of the requested endorsement. Endorsements must be received before final GB approval and before the licensed practitioner can provide patient care. The GB or a delegated GB committee retains the final authority to grant, renew, or deny privileges after considering the recommendations of the medical staff.

ACCC initial reviews are not considered professional review actions and are not reportable to the National Practitioner Data Bank, as the applicant does not meet our threshold criteria. High-risk credential findings can cover any aspect of an LP's application, including but not limited to education, training, licensing, experience, professionalism, and conduct.

A high-risk credentialing finding is identified as an applicant answering yes to any professional practice questions in "Table 1. Credentialing High-Risk Table" on an application. In addition, if any documents or verifications supporting the application illustrate that the applicant should have answered yes to a professional practice question but did not, the applicant is contacted to confirm the response. Please note: The numbers associated with the Professional Practice Questions correspond with the questions on the applications.

Table 1. Credentialing High-Risk Table

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

	7. Have you ever been the subject of a complaint, or have you ever been notified in writing that you have been investigated as the possible subject of a criminal or civil action by any state or federal agency that licenses providers?
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	9. Have you ever been cautioned, reprimanded, or disciplined by any institution, any local, state, or national professional society, regulatory agency, or place of employment? 10. Has your employment and or clinical privileges at any hospital, clinic, or other healthcare setting ever been denied, suspended, revoked, reduced, restricted, not renewed, voluntarily or involuntarily relinquished, denied renewal, or has probation ever been invoked?
Subject of a civil, criminal, or administrative action regarding sexual misconduct, child abuse, domestic violence, elder abuse, or other violent crimes;	8. Have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action by any healthcare organization (e.g., hospital, HMO, PPA, IPA), professional group or society, licensing board, certification board, PSRO or PRO? 22. Have you ever been the subject of a civil or criminal complaint or administrative action, or are you being investigated as the possible subject of a civil, criminal, or administrative action regarding sexual misconduct, child abuse, domestic violence, elder abuse, or any other violent crimes?
Any arrest, charge, conviction, or sentence for the following crimes: Driving under the influence (DUI) or while impaired or intoxicated	25. Do you have any reason to believe that you could pose a risk to the safety or well-being of patients? 27. Have you ever been arrested, cited, charged with or convicted of a felony or misdemeanor other than minor traffic violations, regardless of the outcome? This includes withheld judgements and matters that have been expunged.
Any sexual misconduct	22. Have you ever been the subject of a civil or criminal complaint or administrative action, or are you being investigated as the possible subject of a civil, criminal, or administrative action regarding sexual misconduct, child abuse, domestic violence, elder abuse, or any other violent crimes? 27. Have you ever been arrested, cited, charged with, or convicted of a felony or misdemeanor other than minor traffic violations, regardless of the outcome? This includes withheld judgments and matters that have been expunged.
Illegal drugs forbidden by federal law	23. Are you aware of any impairment, including but not limited to a medical impairment, that you or an objective third party might think would limit your ability to meet the duties associated with clinical staff membership? (If a reasonable accommodation would allow you to exercise your clinical privileges and clinical staff duties completely and

	safely, please refer to the Indian Health Manual, Part 1, Chapter 14, for additional information on requesting accommodation.) 24. Are you currently engaged in illegal use of any legal or illegal substances? 27. Have you ever been arrested, cited, charged with, or convicted of a felony or misdemeanor other than minor traffic violations, regardless of the outcome? This includes withheld judgments and matters that have been expunged.
Intimate partner violence or other violent crimes	22. Have you ever been the subject of a civil or criminal complaint or administrative action, or are you being investigated as the possible subject of a civil, criminal, or administrative action regarding sexual misconduct, child abuse, domestic violence, elder abuse, or any other violent crimes? 27. Have you ever been arrested, cited, charged with or convicted of a felony or misdemeanor other than minor traffic violations, regardless of the outcome? This includes withheld judgements and matters that have been expunged.
Not Board Certified or Board Eligible or historically exempt from the Board Certification/Eligible Requirement	None

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

3. Has your license ever been voluntarily or involuntarily withdrawn?
11. Have you ever voluntarily or involuntarily withdrawn your application for clinical privileges or terminated clinical privileges prior to a hospital or health facility's governing board's final decision?
12. Have you ever been reprimanded, censured, excluded, suspended, disqualified and/or participation voluntarily withdrawn, to avoid an investigation by Medicare, Medicaid, TRICARE, and/or any other governmental health related programs?
13. Have Medicare, Medicaid, TRICARE, PRO authorities, and/or any other third-party payers ever brought charges against you for alleged inappropriate fees, and/or quality of care issues?
14. Has any information pertaining to you, including malpractice judgements and/or disciplinary action, ever been reported to the National Practitioner Data Bank or any other practitioner data bank, or any other federal or state board oversight authority?
17. Have you ever had a claim for professional negligence asserted against you? If yes, you are required to note your final judgement and settlements in the Malpractice Claims section of this application.
18. Have liability claims, judgements or settlements ever been made against a hospital, corporation, or the United States Government in professional liability suits based on a case with which you

were professionally associated? If yes, you are required to note the final judgement and settlements involving yourself as a practitioner in the Malpractice Section of this application.

19. Have you ever had professional liability coverage denied, refused, or canceled by a professional liability insurance company?
20. Have you ever withdrawn from or been suspended, dismissed or expelled from a professional school or postgraduate training program, or has any third party ever attempted to have you withdrawn, suspended, dismissed, or expelled from a professional school or postgraduate training program?
21. Have you ever been placed on probation or taken a leave of absence from medical, dental, or other graduate school or postgraduate training program?
26. Has it been more than 12 months since you have provided patient care in a professional setting?
28. Were you ever the subject of any disciplinary action at any educational (college) or training (residency, fellowship, internship, etc.) programs?

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

Risk Management

Clinical risk management that supports quality and safe patient care is an IHS priority. Clinical administrators and licensed practitioners should review and familiarize themselves with the IHS Risk Management Manual. This manual discusses risk management related to medical care and medical malpractice tort claims within the federal system. Risk management techniques will improve the quality of patient care and proactively reduce the probability of an adverse outcome becoming a medical malpractice claim. It is also essential to analyze and learn from the tort claims that have occurred concerning system issues that require intervention. In both situations, the overall goal in healthcare risk management is to minimize the risk of harm to patients, liability exposure of healthcare providers, and financial loss to the agency.

Section 8: Shared Documents

Sharing of Credentialing and Privileging Documents and Verifications
All requests for credentialing records, including Freedom of Information and medical quality assurance requests, must be approved through the Service Unit Privacy Act Liaisons and/or the Area Office Privacy Coordinator. 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 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 credentialing records with IHS facilities:
The at-a-glance 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	No	Facility Specific	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.

Credentialing	Facility Specific	Shared (Global)
Summary	Display Only No Data Entry	Display Only No Data Entry
Demographic		X
Cycles	X	
Appointment	X	
Address		X
Hospitals		X
Education/Training		X
Other References		X
Peer References		X
Licenses/Credentials		X
Board Certifications		X
Specialties	X	
Insurance		X
Medical History		X
Files	X (unless marked global)	X (if marked global)
Verification Log	X	

Checklists	X	
Associates	Facility Specific	Shared
Supervisors	X	
Coverage	X	
Referrals	X	
Additional Items	Facility Specific	Shared
Dues	X	
Other Events	X	
Incidents/Claims	X	
Aliases		X
Employment	X	
Leadership	X	
Passports/Visas		X
Medical Societies		X
Notes	X	
Verification Enrollment	X	
Jump To	Facility Specific	Shared
View Privileges	X	
Record Privileges	X	
Proctor	X	
Enrollment	X	
Mail Log	X	

Section 9: Privileging Process

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

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

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

Current Competency
The MEC and GB ensure that only qualified, competent LPs perform procedures and provide patient care. 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.

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 30 days at one time and 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 information necessary to process their reappointment on time or when the file's verification, review, and approval are not conducted on time. Documentation of the service hardship and notification to the Area CMO must be filed in the 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.*

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

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

- 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, clean file (defined in this manual) may be considered for temporary privileges or expedited review and approval. Temporary privileges shall follow the facility's accrediting body standard requirements, facility medical staff bylaws and policies, the agency policy, and the SOP manual. Applicants granted temporary clinical privileges are subject to the same credentialing process as other applicants. If the practitioner's license is not renewed, is revoked, restricted, or there is cessation of appropriate liability insurance coverage (as applicable), temporary privileges shall cease immediately.

Section 10: Emergency and Disaster Privileges

Emergency Privileges
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 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 on one of several disaster management teams. Although these LPs are identified as members of a disaster management team or by personal reference, the medical staff services department must still try to primary source verify each LP's licensure within 72 hours, if possible. The medical staff 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 anticipates 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 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.

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.
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.

Section 11: Staff Designations and Appointment Page 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 in the software:

- **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.

Category

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). This drop-down 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 a LP separates from their appointment to the medical staff. These examples help illustrate the specific circumstances under which each reason might be applied.

- **Provider Assignment Ended:** LP’s contract concluded and was not renewed. The status would be marked as “Provider Assignment Ended.” <u>An exit summary is required.</u>

- **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 the organization):** 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.
- **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-PSR:** PSR/HR determined that the applicant is unfavorable for hire with the Indian Health Service. This is not reportable to NPDB as it is not a medical staff action. No exit summary is required unless the LP has been working with a pre-clearance status and the Defense Counterintelligence and Security Agency returns an unfavorable result.

Section 12: Appointment Timeframes and Turnaround Times

Appointment Timeframes
Appointment timeframes indicate how often credentialing and re-credentialing 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 or not 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 or not 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 or not this LP is archived. This field is checked if a 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 a 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 a 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) or on paper approval forms will include in the final outcome the title and role of the signatory (e.g., Clinical Director, Chair of the MEC.)
- All signatories should utilize a "recommend" selection, with only the Chair of the GB or their designee using the "approval" selection.
- 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 a 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

Section 13: Credentialing by Proxy

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

This SOP is for credentialing 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, only the required standards, policies, and standard work necessary for the CBP process and documentation in MD-Staff. CBP does the following:

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

The CBP process provides a path for the OS to accept a Medicare-participating organization (hospital) or a distant site telemedicine entity's (DSTE) credentialing work for remote telemedicine practitioners rather than requiring the full traditional credentialing process for practitioners who will never physically present to OS facilities. While the CBP process is not required to credential distant site (DS) telemedicine practitioners, it has been the agency's preferred method in the IHS since 2012. Practitioners providing in-person or onsite services must be fully credentialed and privileged using the traditional credentialing process.

Standard Work – Credentialing by Proxy

The elements below outline the CBP process of using the credentialing and privileging decision of DS hospitals or DSTEs and using the information to make its privileging decision for telemedicine practitioners providing telemedicine services in federal IHS facilities.

- Credentialing by Proxy Written Agreement – To utilize CBP, the OS must enter into a written agreement with the Medicare-participating organization or a DSTE that satisfies all CMS CoPs. For IHS federal facilities, a sample agreement is available. OGC recommends that the agreement be reviewed by the appropriate contracting officer handling the contract to ensure the terms of the contract are not in conflict with the agreement. The CBP agreement can include one or multiple IHS federal facilities. Review the agreement and consider the services being contracted. Verify that the privileges and services of each DS LP are listed in the agreement or obtain IHS facility-specific privilege forms for each DS practitioner. Then, determine if IHS background checks are required according to IHS policy as stipulated in the agreement.

- Medical Staff Bylaws – The medical staff must adopt and enforce bylaws that include criteria to determine privileges to be granted to individual practitioners and a procedure for applying the criteria that are subject to §482.12(a)(8)(9) and §482.22(a)(3)(4). The OS has approved bylaws or policies that include language that enables the OS to rely upon the hospital or DSTE credentialing decisions when making their own credentialing and privileging decisions regarding DS telemedicine practitioners.
- 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, policies, and procedures related to telemedicine credentialing, etc. The DSTE is a Medicare-participating organization or satisfies all CMS final rule CBP requirements.
- Schedule 1 Roster – The DS submits a schedule 1 roster and includes all practitioners who have had their credentials verified by the DS and have approved privileges at the DS that will be performed at the OS. Any time LPs are removed or added, a new schedule 1 roster needs to be submitted by the DS and approved by the OS GB; both the DS and OS sign and date the roster. The initial schedule 1 roster should not be sent to the OS GB for approval until all DS practitioners listed on the initial schedule 1 have completed all IHS-required documentation and verifications for a CBP LP.
- DS Decision Notification Letter – A copy of the DS LP's decision notification letter is required to document that the DS currently approves the practitioner to perform privileges. The agreement also requires the DS to notify the IHS of any changes in the practitioner's status, credentialing, or privileging.
- Privileges – A copy of the DS LP's approved privileges and either 1) a copy of requested IHS area/facility-specific privileges or 2) the agreement has listed the services and specific privileges to be provided by the DS LPs. The OS shall also ensure that the privileges it grants each telemedicine practitioner at the OS site do not exceed those granted to that telemedicine practitioner by the DS.
- Medical Licensure – All active and inactive medical state licenses for DS practitioners approved on a schedule 1 must be verified. If the DS verifies all active and inactive medical licenses and the IHS area/facility includes that service in their agreement, the DS agrees. In that case, IHS can rely on the DS state license verifications. Suppose the DS does not verify all active and inactive medical state licenses. In that case, the IHS should collect all active and inactive state license information from the DS and conduct the verifications with documentation maintained in MD-Staff. The DS practitioner must hold a current, active, full, and unrestricted license or registration from a state, the District of Columbia, the Commonwealth of Puerto Rico, or a territory of the United States.
- National Practitioner Data Banks (NPDB) – Each DS practitioner on the schedule 1 shall be enrolled as a continuous query in the NPDB for the time they are on the schedule 1 with IHS, unless the OS has made the DS an authorized agent, with documentation maintained in MD-Staff.
- Office of Inspector General (OIG) and SAMS Verifications—Each IHS facility where a DS practitioner is approved for privileges shall complete OIG and SAM verifications, with documentation maintained in MD-Staff.
- Signed IHS Release – Each DS practitioner must have a signed IHS Conditions of Application and Release Form in MD-Staff.

The IHS CBP Intake Form is an OMB-approved IHS CBP Intake Form has been developed and is available to send to the DS. It provides the information necessary for the practitioner's profile in MD-Staff. This intake form is optional.

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

The DS practitioners are often approved for more privileges at the DS than what is contracted for at the OS. Therefore, it is essential for the IHS to either identify the facility-specific privileges to be provided in the agreement or obtain IHS area/facility-specific privileges. This helps surveyors identify what privileges are facility-specific.

Document Storage in MD-Staff

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

The IHS MSP will ensure the following information is collected and maintained in MD-Staff for CBP 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.
- **Files (Facility or Global – Global are shared)**
    - **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
        6. **Upload File**
        7. **Save**
        8. The MSP should set up an alarm in MD-Staff to alert at least 90 days before the LP's DS appointment is about to expire. Note that a new appointment letter and privileges will need to be obtained from the DS for the next reappointment.

9. Review the DS privileges to ensure that the DS LP is not providing services at the OS that are not approved at the DS.

- **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.
- **NPDB Continuous Query** – Store this verification in MD-Staff under the Verification Log.
- **OIG and SAM verification** – Store these verifications in MD-Staff under the Verification Log.
- **IHS Conditions of Application and Release** – Signed by the LP. Store this document in the Files section under Statement of Release.

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

Quality Assurance and Ongoing Monitoring

- The OS will monitor the performance of the practitioners covered by the CBP agreement. To the extent permitted by Federal law, OS will report all adverse events and patient and staff complaints to the DS within the time specified in the Agreement.
- To the extent permitted by federal law, the OS will submit an annual report to the DS that will, at a minimum, include all adverse events and patient and staff complaints about the telemedicine services provided by the DS practitioner to the OS's patients.
- 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.
- The DS will provide an updated accreditation award letter when accreditation is renewed or a letter stating that the organization is a Medicare-participating organization.

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

Section 14: MSP Training Competencies and Certifications

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

- Indian Health Manual, Part 3, Chapter 1, Medical Credentials and Privileges Review Process Policy
- Indian Health Service Standard Operation Procedures for Credentialing and Privileging (this SOP).
- The area and/or facility's local medical staff bylaws, rules and regulations, and any policies that guide medical staffing.
- The facility's accrediting body chapters, sections, or parts of the accreditation manual that address medical staffing, credentialing and privileging.
- National Provider System, System of Records Notice (SORN), 63 Federal Register 40297-40300 (July 28, 1998).
- Request for Records Disposition Authority, IHS Medical Staff Credentialing and Privileging Records, DAA-0513-2018-0002.
- Corresponding professional service IHM manuals for licensed practitioners, e.g., Dental, Nursing, Physician Assistant, Pharmacy, Behavioral Health, etc.
- Indian Health Service Medical Staff Credentials and Privileges Records, SORN, 88 Federal Register 33151-33156 (May 23, 2023).
- Centers for Medicare & Medicaid Services, Conditions for Coverage and Participation (CoP)—Hospitals.
- National Practitioner Data Bank Guidebook (Oct. 2018).
- Employee Medical File SORN, 75 Fed. Reg. 35099-35102 (June 21, 2010).
- Equal Employment Opportunity Commission (EEOC), Enforcement Guidance on Disability-Related Inquiries and Medical Examinations of Employees Under the ADA, EEOC-CVG-2000 (July 27, 2000).
- EEOC, Enforcement Guidance: Preemployment Disability-Related Questions and Medical Examinations, EEOC-CVG-1995 (Oct. 10, 1995).

In addition, all IHS MSPs should:

- Sign up for the IHS Medical Staff Listserv
- Join the IHS HQ Credentialing and Privileging SharePoint site
- Attend the Monthly IHS MSP Office Hours held on the third Tuesday of each month from 4 to 5 pm EST on Microsoft Teams. Reach out to your Area MSP Coordinator or the OQ Credentialing Coordinator to be forwarded the invite.
- Attend the Monthly IHS MSP eLearning Sessions held on the fourth Tuesday of each month from 11 am to 12 pm EST on Microsoft Teams. Reach out to your Area MSP Coordinator or the OQ Credentialing Coordinator to be forwarded the invite.

National Credentialing Certifications

IHS MSPs are encouraged to seek a national credentialing certification.

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

How does taking these certification exams directly benefit me?
Passing the CPCS, CPMSM, and/or the MD-Staff Certification Exam will enhance performance and leadership by:

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

National Certifications
The two types of national certification are:

- Certified Provider Credentialing Specialist (CPCS®)
- Certified Professional Medical Services Management (CPMSM®)

Verification: Visit the certification verification webpage to verify those currently holding an NAMSS certification and to identify when renewal dates are due.

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

- **Self-Paced MD-Staff Academy Courses** - regimented courses that include knowledge checks and a final quiz. Designed to educate and test user retention. These courses are also recommended if you're interested in sitting for the MD-Staff Level 1 Certification Exam.
- **On-Demand Videos** - short videos available in the Help Center. Perfect for quick and specific training.
- **Live Webinars** - hosted weekly by MD-Staff trainers. Ideal environment for networking with other clients and engaging with a live instructor.
- **User Manual** - online user manual contains all the product documentation needed to answer technical or workflow questions. Most articles include step-by-step instruction and screenshots.

Call the ASM Support Team at 1-800-736-7276 for software questions or email them.

Once MSPs become familiar with MD-Staff, IHS highly encourages them to become MD-Staff Certified Users by taking the Level 1 Certification Exam to demonstrate competency.

Section 15: 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, please get in touch with your Lead Area MSP first. 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
- Contracts/Hiring FAQs
- Documentation FAQs
- File Management/Sharing FAQs
- Forms FAQs
- Licenses/Credentials FAQs
- Malpractice FAQs
- Professional Practice Evaluations FAQs
- Verification FAQs
- Application 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, Advanced Practice Registered Nurses, (IHM 3-4.11), Physician Assistants, Registered Dietician Nutritionists/Registered Dieticians (as approved by the medical staff in the hospital setting per IHM 3.5-4 C.2a), Clinical Pharmacists (IHM 3.7-11 D.), doctorate level clinical psychologists (IHM 3.14-5 8c), Occupational Therapists (IHM 3.15-3 B.2), Physical Therapists (IHM 3.15-3 B.2), Speech-Language Pathologists (IHM 3.15-3 B.2), and any other licensed practitioners identified in the facility's medical staff bylaws.

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.

<u>Board Certification FAQs</u>

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.

<u>Contracts/Hiring FAQs</u>

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 are eligible if they meet the following requirements:

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

<u>Documentation FAQs</u>

Q: If a 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: 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.

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 employee's 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 having problems obtaining the affiliation letter, check to ensure the correct URL and login information are being used.

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 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.

Appendix

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

Appendix 1

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

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

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

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

Appendix 2
MD-Staff Job Aid for Exit Clinical Performance Summary (ECPS)

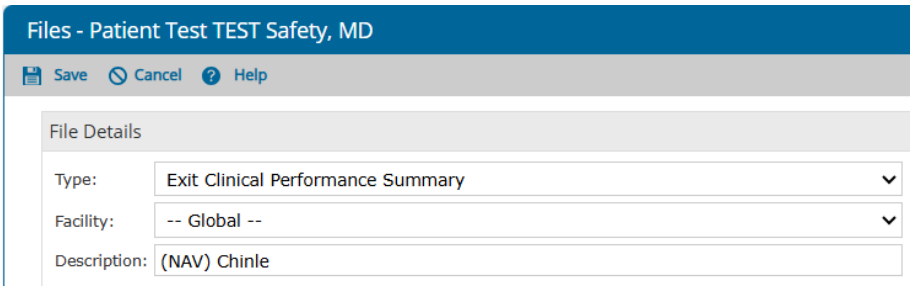
Purpose: The purpose of this job aid is to describe the process of completing the Exit Clinical Performance Summary (ECPS) for credentialed and privileged LPs.

Process: When a licensed practitioner (LP) leaves employment with the IHS, the facility clinical director will capture a summary of the LP's competency and conduct on the IHS ECPS at the time of departure. The CD may designate another individual who is a peer to complete the ECPS, but the CD maintains the responsibility to ensure completion. The goal is to complete and retain an ECPS for every LP in MD-Staff whose privileges have been voluntarily or involuntarily terminated. This document is an internal document to IHS and is protected by 25 U.S.C. § 1675.

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 Other References tab
    c. To set up the entry:
        i. Click **Add**
        ii. Fill in the following information:
            1. **Source** – Add your facility
            2. **Email** – Add the email of the individual (Area CMO, facility Clinical Director, MEC designee, or department chief) 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.



5. Navigate back to the Other Reference tab and uncheck the "In Use" checkbox for the ECPS entry to ensure that the pronto isn't sent again if verifications are automatically completed with any future application imports.
6. Navigate to the Verification Log. If the ECPS has no negative marks, uncheck the negative status. If the ECPS has negative responses regarding the LP's performance, keep the negative status checked Yes.

Appendix 4
IHS Initial Appointment Audit Form

This Initial Appointment Audit Form is based on the IHM 3-1 policy and SOP requirements. Areas and service units may have stricter but not less strict requirements. This form will be used in any IHS HQ audits performed on any initial appointment file audits.

Provider Name:	Service Unit:	Area:

DOCUMENTS / TASKS	Compliant/ Completed?	# NC	Comments
Workflow			
Alarms (appointment, life support, board certification, DEA/CDS/DPS, insurance, NPDB, and state license)	Choose an item.		
Summary			
Photo of the provider	Choose an item.		
Demographic			
Degree	Choose an item.		
Field of Licensure	Choose an item.		
Cycles			
Aiva Cycle selected	Choose an item.		
Appointment			
Application Sent			
Application Submitted	Choose an item.		
Application Received	Choose an item.		
Application Type	Choose an item.		
Application Status – populated as “One Year”	Choose an item.		
Application Processed	Choose an item.		
MEC Approval	Choose an item.		
Board Approval	Choose an item.		
Initial Appointment	Choose an item.		
Last Appointment	Choose an item.		
Next Appointment	Choose an item.		
Credentialing Complete Checkbox Checked	Choose an item.		
Status	Choose an item.		
Category	Choose an item.		
Dept. 1	Choose an item.		
Physical Location	Choose an item.		
Staff Type	Choose an item.		
Corporate Status	Choose an item.		
On Staff Checkbox	Choose an item.		
Dates are in chronological order and make sense	Choose an item.		
Hospitals			
All current and historical affiliations from CV/resume are listed	Choose an item.		
Affiliation PSV complete – last 5 years	Choose an item.		

OMB global verification or another appropriate PSV used	Choose an item.		
Reason for leaving documented	Choose an item.		
Documents 3 unverifiable attempts, if unable to obtain PSV (name, date of request, and verification methods)	Choose an item.		
No duplicate entries	Choose an item.		
From and To dates match PSV	Choose an item.		
Education/Training			
All Education and post-graduate training are listed (compare with CV/resume)	Choose an item.		
Qualifying degree and post-graduate training PSV complete (includes ECFMG)	Choose an item.		
All Education Types are correct	Choose an item.		
Degree is listed	Choose an item.		
Subject is listed (field of study or focus)	Choose an item.		
OMB global verification or another appropriate PSV used	Choose an item.		
Documents 3 unverifiable attempts, if unable to obtain PSV (name, date of request, and verification methods)	Choose an item.		
No duplicate entries	Choose an item.		
From and To dates match PSV	Choose an item.		
Other References			
All current and past work history since college graduation is listed (compare with CV/resume)	Choose an item.		
Work History PSV complete – last 5 years	Choose an item.		
OMB global verification or another appropriate PSV used	Choose an item.		
Documents 3 unverifiable attempts, if unable to obtain PSV (name, date of request, and verification methods)	Choose an item.		
No duplicate entries	Choose an item.		
From and To dates match PSV	Choose an item.		
Peer References			
Peer Reference #1 verification	Choose an item.		
Peer Reference #2 verification	Choose an item.		
Peer references have equal or greater credentials than the applicant	Choose an item.		
Peer references have worked directly with the applicant within the past two years (check From and To dates)	Choose an item.		
OMB global verification or another appropriate PSV used	Choose an item.		
No duplicate entries	Choose an item.		
License/Credentials			
All active and inactive state licenses, DEA, CDS, DPS, and other licenses/registrations are listed (compare with CV/resume)	Choose an item.		
Active DEA/CDS/DPS Registration PSV complete	Choose an item.		
Active DEA/CDS/DPS Registration expiration matches PSV	Choose an item.		
Active State Licenses PSV	Choose an item.		
Active State Licenses expiration matches PSV	Choose an item.		
Inactive State License PSV	Choose an item.		
Inactive State License expiration matches PSV	Choose an item.		

Life Support Certificates attached (not for telehealth)	Choose an item.		
Life Support expiration matches the certificate expiration	Choose an item.		
All License Types are correct	Choose an item.		
Documents 3 unverifiable attempts, if unable to obtain PSV (name, date of request, and verification methods)	Choose an item.		
No duplicate entries	Choose an item.		
Board Certifications			
All current and previously held board certifications are listed (compare with CV/resume)	Choose an item.		
If not certified, an explanation is listed in the Comments section	Choose an item.		
Board Certification PSV complete	Choose an item.		
Board Certification expiration matches PSV	Choose an item.		
Board Certification fields complete	Choose an item.		
No duplicate entries	Choose an item.		
Insurance			
Malpractice insurance carriers are listed – last 5 years (compare with CV/resume)	Choose an item.		
FTCA listed – for IHS employees	Choose an item.		
Current malpractice insurance PSV through the carrier	Choose an item.		
OMB global verification or another appropriate PSV used	Choose an item.		
Current malpractice insurance expiration matches PSV	Choose an item.		
Current malpractice insurance COI includes LP name, dates, affiliation, and coverage amounts	Choose an item.		
Documents 3 unverifiable attempts, if unable to obtain PSV (name, date of request, and verification methods)	Choose an item.		
No duplicate entries	Choose an item.		
Files			
Appropriate Application completed	Choose an item.		
Privileges requested by the applicant	Choose an item.		
Professional Practice Questions complete	Choose an item.		
OMB-approved IHS Conditions of Participation & Release Form used	Choose an item.		
IHS Conditions of Participation & Release Form signed by the applicant	Choose an item.		
Gap Report (no gaps > 30 days or gaps explained)	Choose an item.		
Explanations for negative answers/red flags documented	Choose an item.		
CV/Resume	Choose an item.		
Continuing Education – previous 2 years, unless post-graduate training completed in the prior 2 years	Choose an item.		
File Type names are correct	Choose an item.		
Verifications			
SAM/GSA Verification	Choose an item.		
Medicare Opt-out Verification	Choose an item.		
NPDB Query	Choose an item.		
NPI Verification	Choose an item.		
OIG Verification	Choose an item.		

IHS ID Attestation Form complete	Choose an item.		
Jump To → View Privileges			
Privileges are listed	Choose an item.		
LP meets all privilege criteria, per privilege form	Choose an item.		
Privileges decision is documented	Choose an item.		
VComm			
Medical staff membership and/or privileges decision is documented	Choose an item.		
Recommendations and approvals in VComm include the title and role of the signatory in the outcome	Choose an item.		
Reviewer Name & Date Completed:			

 # NC – Number non-compliant/not complete

Appendix 5
IHS Reappointment Audit Form

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

Provider Name:	Service Unit:	Area:

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

Reason for leaving documented	Choose an item.		
Documents 3 unverifiable attempts, if unable to obtain PSV (name, date of request, and verification methods)	Choose an item.		
No duplicate entries	Choose an item.		
From and To dates match PSV	Choose an item.		
Education/Training			
New education or post-graduate training since the last appointment is PSV, if required for the position or privileges (includes ECFMG)	Choose an item.		
All Education Types are correct	Choose an item.		
Degree is listed	Choose an item.		
Subject is listed (field of study or focus)	Choose an item.		
OMB global verification or another appropriate PSV used	Choose an item.		
Documents 3 unverifiable attempts, if unable to obtain PSV (name, date of request, and verification methods)	Choose an item.		
No duplicate entries	Choose an item.		
From and To dates match PSV	Choose an item.		
License/Credentials			
Active DEA/CDS/DPS Registration PSV complete	Choose an item.		
Active DEA/CDS/DPS Registration expiration matches PSV	Choose an item.		
Active State Licenses PSV	Choose an item.		
Active State expiration matches PSV	Choose an item.		
Life Support Certificates attached (not for telehealth)	Choose an item.		
Life Support expiration matches the certificate expiration	Choose an item.		
All License Types are correct	Choose an item.		
Documents 3 unverifiable attempts, if unable to obtain PSV (name, date of request, and verification methods)	Choose an item.		
No duplicate entries	Choose an item.		
Board Certifications			
Board Certification PSV at last expiration	Choose an item.		
Board Certification expiration matches PSV	Choose an item.		
Board Certification fields complete	Choose an item.		
No duplicate entries	Choose an item.		
Insurance			
FTCA listed – for IHS employees	Choose an item.		
Current malpractice insurance for contractors PSV through the carrier at last expiration	Choose an item.		
OMB global verification or another appropriate PSV used at last expiration	Choose an item.		
Current malpractice insurance expiration matches PSV	Choose an item.		
Current malpractice insurance COI includes LP name, dates, affiliation, and coverage amounts	Choose an item.		
Documents 3 unverifiable attempts, if unable to obtain PSV (name, date of request, and verification methods)	Choose an item.		
No duplicate entries	Choose an item.		
Files			

Appropriate Application completed	Choose an item.		
Privileges requested by the applicant	Choose an item.		
Professional Practice Questions complete	Choose an item.		
OMB-approved IHS Conditions of Participation & Release Form used	Choose an item.		
IHS Conditions of Participation & Release Form signed by the applicant	Choose an item.		
Explanations for negative answers/red flags documented	Choose an item.		
Continuing Education	Choose an item.		
File Type names are correct	Choose an item.		
Verifications			
SAM/GSA Verification	Choose an item.		
Medicare Opt-out Verification	Choose an item.		
NPDB Query	Choose an item.		
NPI Verification	Choose an item.		
OIG Verification (or NPDB CQ enrollment)	Choose an item.		
Jump To → View Privileges			
Privileges are listed	Choose an item.		
LP meets all privilege criteria, per privilege form	Choose an item.		
Privileges decision is documented	Choose an item.		
VComm			
Medical staff membership and/or privileges decision is documented	Choose an item.		
Recommendations and approvals in VComm include the title and role of the signatory in the outcome	Choose an item.		
Reviewer Name & Date Completed:			

 # NC – Number non-compliant/not complete

Appendix 6
IHS Disaster Privileges Audit Form

This Disaster Privilege Audit Form is based on the IHM 3-1 policy, SOP, and best practices. Areas and service units may have stricter but not less strict requirements. This form will be used in any IHS HQ audits for LPs granted disaster privileges.

Provider Name:	Service Unit:	Area:

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

 # NC – Number non-compliant/not complete

Appendix 7
IHS Credentialing by Proxy Audit Form

This Credentialing by Proxy Audit Form is based on the IHM 3-1 policy, SOP, and best practices. Areas and service units may have stricter but not less strict requirements. This form will be used in any IHS HQ audits for LPs credentialed by proxy.

Provider Name:	Service Unit:	Area:

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

License/Credentials			
DEA/CDS/DPS PSV (unless DS completes, per agreement)	Choose an item.		
Active State Licenses PSV (unless DS completes, per agreement)	Choose an item.		
Inactive State License PSV (unless DS completes, per agreement)	Choose an item.		
All License Types are correct	Choose an item.		
All License/registration fields completed	Choose an item.		
Documents 3 unverifiable attempts, if unable to obtain PSV (name, date of request, and verification methods)	Choose an item.		
No duplicate entries	Choose an item.		
Files			
CBP Intake Form completed	Choose an item.		
Privileges requested by applicant or included in agreement	Choose an item.		
Professional Practice Questions Complete	Choose an item.		
OMB-approved IHS Conditions of Participation & Release Form used	Choose an item.		
IHS Conditions of Participation & Release Form signed by the applicant	Choose an item.		
CBP written agreement	Choose an item.		
Distant site compliance with Medicare CoP (accreditation award letter, policies/procedures related to CBP, etc.)	Choose an item.		
Schedule 1 Roster signed & dated by both entities	Choose an item.		
Decision letter from originating site	Choose an item.		
Explanations for negative answers/red flags documented	Choose an item.		
File Type names are correct	Choose an item.		
Verifications			
SAM/GSA Verification	Choose an item.		
Medicare Opt-out Verification	Choose an item.		
NPI Verification	Choose an item.		
NPDB Query	Choose an item.		
OIG Verification	Choose an item.		
Jump To → View Privileges			
Privileges listed	Choose an item.		
Privileges do not include services at the OS that are not approved at the DS	Choose an item.		
LP meets all privilege criteria	Choose an item.		
Privileges decision documented	Choose an item.		
VComm			
Medical staff membership and/or privileges decision is documented	Choose an item.		
Recommendations and approvals in VComm include the title and role of the signatory in the outcome	Choose an item.		
Reviewer Name & Date Completed:			

 # NC – Number non-compliant/not complete