

## CREDENTIALING AND PRIVILEGING

**1. REASON FOR ISSUE.** This revised Veterans Health Administration (VHA) Handbook provides VHA procedures regarding credentialing and privileging. **AUTHORITY:** Title 38 United States Code 7304, 7401, 7402, 7405, 7409, and 7461 through 7464; title 45 Code of Federal Regulations (CFR) Part 60; Public Law (Pub. L.) 106-117, sec. 209, Pub. L. 105-33, sec. 4331(c), Pub. L. 104-191, sec. 221, Pub. L. 99-166, sec. 206, and Pub. L. 99-660, sec. 422 and its revisions; 5 CFR Parts 315, 731, and 752; and 38 CFR Part 46.

**2. SUMMARY OF CONTENTS/MAJOR CHANGES.** This revision of VHA Handbook 1100.19 incorporates:

- a. Requirement for Clinical Pharmacy Specialists to be credentialed in accordance with this policy;
- b. Incorporation of requirements for acceptance of facsimile primary source verification;
- c. Reduction of the number of references required for expedited appointment;
- d. Specific requirements for verification of previous VA experience;
- e. Revision to the credentialing and privileging requirements related to telemedicine and Teleconsultation;
- f. Guidance on the privileging process; and
- g. Clarification on the due process procedures afforded practitioners for reduction or revocation of clinical privileges.

**3. RELATED ISSUE.** VHA Directive 1100.19.

**4. RESPONSIBLE OFFICE.** The Office of Quality, Safety, and Value (10A4E), is responsible for the contents of this VHA Handbook. Questions may be addressed to 919-474-3905.

**5. RESCISSIONS.** VHA Handbook 1100.19, dated November 14, 2008, is rescinded.

**6. RECERTIFICATION.** This VHA Handbook is scheduled for recertification on or before the last working day of October 2017.

Robert A. Petzel, M.D.  
Under Secretary for Health

DISTRIBUTION: E-mailed to the VHA Publications Distribution List 10/16/2012

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## CREDENTIALING AND PRIVILEGING

### 1. PURPOSE

This Veterans Health Administration (VHA) Handbook provides VHA procedures regarding credentialing and privileging of all health care professionals who are permitted by law and the facility to practice independently. **NOTE:** *This Handbook does not apply to trainees, including physician residents, except those who function outside the scope of their training program; i.e., Medical Officer of the Day advanced Fellows, or certain Chief Resident positions.*

**AUTHORITY:** Title 38 United States Code 7304, 7401, 7402, 7405, 7409, and 7461 through 7464; title 45 Code of Federal Regulations (CFR) Part 60; Public Law (Pub. L.) 106-117, sec. 209, Pub. L. 105-33, sec. 4331(c), Pub. L. 104-191, sec. 221, Pub. L. 99-166, sec. 206, and Pub. L. 99-660, sec. 422 and its revisions; 5 CFR Parts 315, 731, and 752; and 38 CFR Part 46.

### 2. DEFINITIONS

a. **Appointment.** The term "appointment" refers to the medical staff. It does not refer to appointment as a VA employee (unless clearly specified), but is based on having an appropriate personnel appointment action, scarce medical specialty contract, or other authority for providing patient care services at the facility. Both Department of Veterans Affairs (VA) employees and contractors may receive appointments to the medical staff.

b. **Associated Health Professional.** The term "Associated Health Professional" is defined as those clinical professionals, other than doctors, of allopathic, dental, and osteopathic medicine.

c. **Authenticated Copy.** The term "authenticated copy" means that each page of the document is a true copy of the original document; each page is stamped "authenticated copy of original" and is dated and signed by the person doing the authentication. **NOTE:** *Facsimile copies of verification documents may be used as primary source verification, if the authenticity of the facsimile is independently verified; there is verification of the identity of the creator, when it was created; and that it is an accurate reproduction of the original documented in writing.*

d. **Credentialing.** The term "credentialing" refers to the systematic process of screening and evaluating qualifications and other credentials, including, but not limited to: licensure, required education, relevant training and experience, and current competence and health status.

e. **Clinical Privileging.** The term "clinical privileging" is defined as the process by which a practitioner, licensed for independent practice (i.e., without supervision, direction, required sponsor, preceptor, mandatory collaboration, etc.), is permitted by law and the facility to practice independently, to provide specified medical or other patient care services within the scope of the individual's license, based on the individual's clinical competence as determined by peer references, professional experience, health status, education, training, and licensure. Clinical privileges must be facility-specific, practitioner-specific, and within available resources.

**NOTE:** *There may be practitioners, who by the nature of their positions, are not involved in patient care (i.e., researchers, administrative physicians, or VHA Central Office staff). These health care professionals must be credentialed, but may not need to be privileged.*

f. **Competency.** The term “competency” is a documented demonstration of an individual having the requisite or adequate abilities or qualities capable to perform up to a defined expectation.

g. **Current.** The term "current" applies to the timeliness of the verification and use for the credentialing and privileging process. No credential is current and no query of the Federation of State Medical Boards (FSMB) is current if performed prior to submission of a complete application by the practitioner to include submission of VetPro. At the time of initial appointment, all credentials must be current within 180 days of submission of a complete application. For reappointment, all time-limited credentials must be current within 180 days of submission of the application for reappointment, including peer appraisals, confirmation of National Practitioner Data Bank (NPDB)-Health Integrity and Protection Data Bank (HIPDB) Continuous Query (CQ) annual registration, and other credentials with expirations.

h. **Independent Practitioner.** The term "independent practitioner" is any individual permitted by law (the statute that defines the terms and conditions of the practitioner's practice in the State of licensure) and the facility to provide patient care services independently, i.e., without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges. This is also referred to as a licensed independent practitioner (LIP). **NOTE:** *Only LIPs may be granted clinical privileges.*

i. **Licensure.** The term "licensure" refers to the official or legal permission to practice an occupation, as evidenced by documentation issued by a State, Territory, Commonwealth, or the District of Columbia (hereafter referred to as “State”) in the form of a license, registration, or certification.

j. **One Standard of Care.** The term "one standard of care" means that one standard of care must be guaranteed for any given treatment or procedure, regardless of the practitioner, service, or location within the facility. In the context of credentialing and privileging, the requirements or standards for granting privileges to perform any given procedure must be the same regardless of whether they are performed by more than one service, more than one type of practitioner, or in more than one location.

k. **Post-graduate (PG).** The term “PG” is the acronym for post-graduate.

l. **Primary Source Verification.** Primary source verification is the documentation from the original source of a specific credential that verifies the accuracy of a qualification reported by an individual health care practitioner. This can be documented in the form of a letter, documented telephone contact, or secure electronic communication with the original source.

m. **Proctoring.** Proctoring is the activity by which a practitioner is assigned to observe the practice of another practitioner performing specified activities and to provide required reports on those observations. The proctor must have clinical privileges for the activity being performed,

but must not be directly involved in the care the observed practitioner is delivering. Proctoring that requires a proctor to do more than just observe, i.e., exercise control or impart knowledge, skill, or attitude to another practitioner to ensure appropriate, timely, and effective patient care, constitutes supervision. Such supervision may be a reduction of privileges (see subpar. 14p(3)(b) for additional information on reduction of privileges).

n. **Teleconsulting.** Teleconsulting is the provision of advice on a diagnosis, prognosis, and/or therapy from a licensed independent practitioner to another licensed independent practitioner using electronic communication and information technology to support the care provided when distance separates the participants, and where hands-on care is delivered at the site of the patient by a LIP.

o. **Telemedicine.** Telemedicine is the provision of care by a LIP that directs, diagnoses, or otherwise provides clinical treatment delivered using electronic communications and information technology when distance separates the practitioner and the patient.

***NOTE:** A crucial consideration in making a distinction between consultation and care is that teleconsultation occurs when the consultant involved recommends diagnoses, treatments, etc., to the consulting practitioner requesting the consult, but does not actually write orders or assume the care of the patient. If the consultant diagnoses, writes orders, or assumes care in any way, this constitutes “care” and requires privileges. Unless noted otherwise in this Handbook, a Medical Staff appointment is required if the practitioner is entering documentation into the medical record, e.g., teleradiology, teledermatology, etc.*

p. **VetPro.** VetPro is an Internet enabled data bank for the credentialing of VHA health care practitioners that facilitates completion of a uniform, accurate, and complete credentials file.

### 3. SCOPE

a. All VHA health care professionals who are permitted by law and the facility to provide patient care services independently must be credentialed and privileged as defined in this Handbook. The requirements of The Joint Commission (TJC) standards and VHA policies have been used to define the processes for credentialing, privileging, reappraisal, re-privileging, and actions against clinical privileges, including denial, failure to renew, reduction, and revocation. This Handbook applies to all VHA LIPs permitted by law and facility to provide direct patient care, including telemedicine, and who are appointed or utilized on a full-time, part-time, intermittent, consultant, attending, without compensation (WOC), on-station fee basis, on-station contract, or on-station sharing agreement basis. The credentialing, but not privileging, requirements of this Handbook apply to those Advanced Practice Registered Nurses (APRN), Physician Assistants (PA), and clinical pharmacy specialists who do not practice as licensed independent practitioners, as well as physicians, dentists, and other practitioners assigned to research or administrative positions not involved in patient care.

b. Policy and procedures related to the denial, failure to renew, reduction, and revocation of clinical privileges, that are based on professional competence, professional misconduct, or substandard care, apply to all health care professionals who are granted privileges within the scope of this Handbook.



c. VetPro is VHA's electronic credentialing system and must be used for credentialing all practitioners who are granted clinical privileges or are credentialed for other reasons. One component of VHA's Patient Safety Program is quality credentialing and the use of VetPro is necessary to reduce the potential for human error in the credentialing process. In addition, documentation other than in VetPro that is required by this Handbook or local policy must be maintained in a paper or electronic medium. The requirements of this policy are the same whether carried out on paper or electronically. For example, if a signature is required and the mechanism in use is electronic, then that modality must provide for an electronic signature.

d. Credentialing and privileging must be completed prior to the initial appointment or reappointment to the medical staff and before transfer from another medical facility. If the primary source verification(s) of the practitioner's credentials are on file (paper or electronic), those credentials that were verified at the time of initial appointment (and are not time-limited or specifically required by this policy or TJC to be updated or re-verified) can be considered verified.

e. All procedures described in this Handbook are applicable to Chiefs of Staff (COS) and facility Directors who are involved in patient care. Differences in specific procedures are noted where applicable.

f. The VHA credentialing and privileging policy applies to licensed health care personnel in VHA Central Office, Veterans Integrated System Network (VISN) offices, and other organizational components that would be credentialed in accordance with this policy if in a VA facility, to include, but not limited to: physicians, dentists, APRNs, PAs, and clinical pharmacy specialists.

(1) In those instances where the VISN Chief Medical Officer (CMO) is not a physician, the CMO must be credentialed in accordance with this Handbook.

(2) Wherever the policy defines an action or responsibility of the medical facility Director, or designee, that role belongs to the head of that organizational component, or designee.

g. Nothing in the VA medical facility Medical Staff Bylaws, Rules, and Regulations can be inconsistent with the law, Department of Veterans Affairs (VA) regulations, this Handbook's policies and procedures, or other VA policies.

#### **4. RESPONSIBILITIES OF THE UNDER SECRETARY FOR HEALTH**

The Under Secretary for Health, or designee, is responsible for ensuring the development and issuance of the VHA credentialing and privileging policy.



## **5. RESPONSIBILITIES OF THE PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH**

The Principal Deputy Under Secretary for Health, or designee, is responsible for ensuring oversight in the development and implementation of VHA credentialing and privileging for licensed health care professionals in VA Central Office, VISNs, and VA medical facilities.

## **6. RESPONSIBILITIES OF THE DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT (10N)**

The Deputy Under Secretary for Health for Operations and Management (10N), is responsible for:

- a. Ensuring that VISN Directors maintain an appropriate credentialing and privileging process consistent with the VHA policy.
- b. Ensuring uniform prototype performance standards are issued for key VHA medical facility managers, such as Directors, Associate or Assistant Directors, Human Resource Management Officers, and COS.
- c. Continuing the monitoring of credentialing and privileging through periodic TJC consultative site visits and other reviews, as applicable.

## **7. RESPONSIBILITIES OF THE VISN CHIEF MEDICAL OFFICER (CMO)**

The VISN CMO is responsible for oversight of the credentialing and privileging process of the facilities within the VISN using a standardized assessment tool as directed by the Deputy Under Secretary for Health for Operations and Management when completing oversight activities.

## **8. RESPONSIBILITIES OF THE FACILITY DIRECTOR**

The ultimate responsibility for credentialing and privileging resides with the facility Director. The facility Director, designated by the Under Secretary for Health as the Governing Body of the facility, is responsible for ensuring:

- a. The labor-management obligations are met prior to implementing a Credentialing and Privileging Program that involves Title 5 or Hybrid Title 38 LIPs who are represented by a professional bargaining unit.
- b. Local facility policy, including Medical Staff Bylaws, Rules, and Regulations, is consistent with this Handbook.
- c. Medical staff leadership and all staff with responsibility in the credentialing and privileging process complete the one-time only training as determined by the Office of Quality and Performance (OQP).

(1) Training must be completed within 3 months of assuming this position.

(2) This training may be accessed through the VA Learning Management System at <https://www.tms.va.gov>.

(3) This target audience includes: Medical Staff and Credentialing Professionals; Clinical Service and Product Line Chiefs; Credentials Committee Members (Professional Standards Boards); Executive Committee of the Medical Staff members; COSs and medical facility Directors; Quality and Performance Improvement professionals; and Risk Managers. **NOTE:** *Additional information may be found at the Employees Education Service (EES) Mandatory Training website at <http://vaww.ees.lrn.va.gov/mandatorytraining>.*

d. Securing all credentialing and privileging documents.

## 9. RESPONSIBILITIES OF THE FACILITY CHIEF OF STAFF (COS)

The facility COS is responsible for:

a. Maintaining the Credentialing and Privileging system.

b. Ensuring that all health care professionals applying for clinical privileges agree to provide continuous care to the patients assigned to them.

c. Ensuring that all health care professionals applying for clinical privileges are provided with a copy of, and agree to abide by, the Medical Staff Bylaws, Rules, and Regulations.

d. Ensuring that the Medical Staff Bylaws are consistent with this Handbook and any other VHA policy related to Medical Staff Bylaws.

e. Ensuring training appropriate staff in direct line of authority complete the training identified in subparagraph 8c.

## 10. RESPONSIBILITIES OF THE SERVICE CHIEF

Each Service Chief's is responsible for:

a. Recommending the criteria for clinical privileges that are relevant to the care provided in the service;

b. Reviewing all credentials and requested clinical privileges, and for making recommendations regarding appointment and privileging action; documenting these recommendations in VetPro; and

c. Monitoring and surveillance of the professional competency and performance of those who provide patient care services with delineated clinical privileges. This includes both the focused professional practice evaluation for new privileges (practitioners new to the facility as well as practitioners requesting new privileges) and the ongoing monitoring and continued

surveillance over time. **NOTE:** *The title applies to Service Line Directors, Product Line Chiefs, and any other equivalent titles.*

d. Ensuring that appropriate staff in direct line of authority complete the training identified in subparagraph 8c. Service Chiefs involved in the credentialing and privileging process are responsible for completing the same training.

## **11. RESPONSIBILITIES OF DIRECTOR, MANAGEMENT REVIEW SERVICE**

The Director, Management Review Service (10B5), is responsible for evaluating progress towards the implementation of recommendations made by external reviewers, such as Office of Inspector General (OIG) and Government Accountability Office (GAO).

## **12. RESPONSIBILITIES OF THE APPLICANT AND PRACTITIONER**

Applicants and appointed practitioners are responsible for:

a. Providing evidence of licensure, registration, certification, and/or other relevant credentials, for verification prior to appointment and throughout the appointment process, as requested.

b. Agreeing to accept the professional obligations delineated in the Medical Staff Bylaws, Rules, and Regulations provided to them. **NOTE:** *There may be practitioners who by the nature of their position may not be located in Central Office. These practitioners are credentialed in accordance with this Handbook, but are not agreeing to accept the professional obligations delineated in the Medical Staff Bylaws since this is not applicable. These practitioners are only agreeing to the completeness and accuracy of the application as well understanding that their professional obligations can be compromised by financial conflicts of interest; and they will therefore avoid conflicts or seek guidance in their management.*

c. Keeping VA apprised of anything that would adversely affect, or otherwise limit, their clinical privileges at the earliest date after notification is received by the practitioner, but no later than 15 days. This includes not only final actions, but also pending and proposed actions.

d. Maintaining licenses, registrations, and certification in good standing and informing the Director, or designee, of any changes in the status of these credentials at the earliest date after notification is received by the practitioner, but no later than 15 days, including, but not limited to any pending or proposed actions.

e. Obtaining and producing all needed information for a proper evaluation of professional competence, character, ethics, and other qualifications. The information must be complete and verifiable. The applicant has the responsibility for furnishing information that will help resolve any questions concerning these qualifications. Failure to keep VA fully informed on these matters may result in administrative or disciplinary action.

### 13. CREDENTIALING (i.e., the Initial Appointment, Reappointment, or Reappointment After a Break in Service)

a. **Provisions.** Health care professionals must be fully credentialed and privileged prior to initial appointment or reappointment, except as identified in subparagraphs 13o, 13p, 14e, and 14f.

b. **Procedures.** Credentialing is required to ensure an applicant has the required education, training, experience, physical and mental health, and skill to fulfill the requirements of the position and to support the requested clinical privileges. This paragraph contains the administrative requirements and procedures related to the initial credentialing and reappraisal of practitioners who plan to apply for clinical privileges.

(1) The credentialing process includes verification, through the appropriate primary sources, of the individual's professional education; training; licensure; certification and review of health status; previous experience, including any gaps (greater than 30 days) in training and employment; clinical privileges; professional references; malpractice history and adverse actions; or criminal violations, as appropriate. Except as identified in subparagraph 13a., medical staff and employment commitments must not be made until the credentialing process is completed, including screening through the appropriate State Licensing Board (SLB), FSMB, and the NPDB-HIPDB. All information obtained through the credentialing process must be carefully considered before appointment and privileging decision actions are made.

(2) The applicable Service Chief reviews the credentialing file and requested privileges and make recommendations regarding the appointment. The folder and recommendations are reviewed by the credentialing committee and then submitted with recommendations to the medical staff's Executive Committee.

(3) All applicants applying for clinical privileges must be provided with a copy of the Facility Medical Staff Bylaws, Rules, and Regulations and must agree in writing or via electronic signature to accept the professional obligations reflected therein.

(4) The applicant has the burden of obtaining and producing all needed information for a proper evaluation of professional competence, character, ethics, and other qualifications. The information must be complete and verifiable. The applicant has the responsibility for furnishing information that will help resolve any questions concerning these qualifications. Failure to provide necessary information, in a reasonable time, may serve as a basis for denial of medical staff appointment and/or privileges, as defined in the facility Medical Staff Bylaws.

c. **Application Forms.** Candidates seeking appointment or reappointment must complete the appropriate forms for the position for which they are applying.

(1) All candidates, requiring credentialing in accordance with this Handbook, must complete an electronic submission of VetPro. VetPro's supplemental attestation questions require applicants to answer questions concerning malpractice, adverse action against licensure, privileges, research, etc., in accordance with TJC and VHA requirements.

(2) The "Sign and Submit" screen in VetPro meets the requirement for the applicant's agreement to provide continuous care and to accept the professional obligations defined in the facility Medical Staff Bylaws, Rules, and Regulations for the facility(ies) to which the application is being made, as well as attesting to the accuracy and completeness of the information submitted. **NOTE:** *For those individuals who are not members of the medical staff, this attestation is still required since all practitioners delivering care at a facility are subject to the Medical Staff Bylaws, Rules and Regulations whether practicing independently, in collaboration with an independent practitioner or under the supervision of such.*

(3) Applicants are required to provide information on all educational, training, and employment experiences, accounting for all gaps greater than 30 days in the candidate's history from date of graduation for the qualifying degree to the date of submission of the application.

(4) If the delay between the candidate's application and reporting for duty is greater than 180 calendar days, the candidate must update all time-limited credentials and information, including, but not limited to: licensure, personal history and competence, and supplemental attestation questions. The updated information must be verified prior to the candidate reporting for duty. The primary source verification of a time-limited credential cannot be greater than 120 days old at the time a practitioner reports for duty. This requirement includes enrollment in the NPDB–HIPDB CQ. **NOTE:** *Delays between a candidate's application and reporting for duty most frequently occur in the case of an individual for whom special waivers (i.e., visa waiver) may be required. Since these processes can be time consuming, information on the candidate's practice or non-practice during the period of delay must be obtained in order to ensure the most appropriate placement of the candidate. A copy of the appropriate application form and any supplemental form(s) are maintained electronically in VetPro. If the applicant provides a resume or curriculum vitae, this is filed in Section I of the credentialing and privileging file.*

#### d. Documentation Requirements

(1) Each privileged health care practitioner must have a Credentialing and Privileging file established electronically in VetPro with any paper documents maintained according to the requirements of the standardized folder identified in Appendix A. Other credentialed health care providers have a credentials file maintained in the same system of records even though they may not be granted clinical privileges. **NOTE:** *Duplication of information documented and maintained in the electronic VetPro file for filing in the paper Credentialing and Privileging file is not allowed.*

(2) Information obtained, to be used in the credentialing process, must be primary source verified (unless otherwise noted) and documented in writing, either by letter, report of contact, or web verification. All credentialing and privileging documents must be secured. Facsimile copies may be used as primary source verification with appropriate authentication of the source providing the information. The source of the facsimile needs to be independently authenticated and the authentication needs to be documented in writing by the authenticator, e.g., entry into comments section of VetPro. A coversheet by itself is not considered independent authentication, but it may be scanned as the last page of the document, not the first, as well as documentation of the independent verification of the sender's source. If independent

authentication of the source cannot be made, the facsimile copy must be followed up with an original document.

(a) Authentication of the source of the facsimile requires the recipient to document knowledge that the appropriate source that owed the verification information transmitted the facsimile. For example, if the recipient of the facsimile confirmed with the verifying entity that the facsimile was indeed transmitted by the verifying entity, then this confirmation should be documented on the facsimile coversheet, signed and dated by the individual completing the independent authentication, as well as the name and title of the confirming individual and the date of confirmation.

(b) When using an Internet source for verification, the following criteria must be considered in determining appropriateness as primary source verification:

1. The web site disclaimer needs to be reviewed to determine the organization's attestation to the accuracy and timeliness of the information. If there is no disclaimer, the web verification needs to be considered as not adequate for verification.

2. There must be evidence that the site is maintained by the verifying entity and that the verification data cannot be modified by outside sources. If not maintained by the verifying entity, the site must include an endorsement by the entity that the site is a primary source verification or the transmission is in an encrypted format.

3. The site must provide information on the status of the credential and pending or final adverse action information as of the date of verification.

4. To avoid issues arising with surveyors, it's advisable to print the disclaimer when the verification is printed. Sites are constantly changing.

(3) There must be follow-up of any discrepancy found in information obtained during the verification process. The practitioner has the right to correct any information that is factually incorrect by documenting the new information with a comment that the previously-provided information was not correct. Follow-up with the verifying entity is necessary to determine the reason for the discrepancy if the practitioner says the information provided is factually incorrect.

(4) Health care professionals with multiple licenses, registrations, and/or certifications are responsible for maintaining these credentials in good standing and of informing the facility Director, the Deputy Under Secretary for Health, the Program Chief Officer, or designee, of any changes in the status of these credentials at the earliest date after notification is received by the practitioner, but no later than 15 days. to include, but not limited to, final actions as well as pending or proposed actions. The Deputy Under Secretary for Health, the facility Director, the Program Chief Officer, or designee, is responsible for establishing a mechanism to ensure that multiple licenses, registrations, and/or certifications are consistently held in good standing or, if allowed to lapse, are relinquished in good standing. The practitioner is required to provide a written explanation for any credentials that were held previously, but which are no longer held or no longer full and unrestricted. The verifying official must contact the SLBs or issuing organization(s) to verify information provided regarding the change. **NOTE:** *There are*



*circumstances when verification from a foreign country is not possible or could prove harmful to the practitioner and/or family. In these instances, full documentation of efforts and circumstances, including a statement of justification, is to be made in the form of a report of contact and filed in the Credentialing and Privileging file in lieu of the document sought.*

(5) If the search for the documents is unsuccessful, or the primary source documents are not received after a minimum of two requests, full written documentation of these efforts, in the form of a report of contact, is to be filed in the credentialing file in lieu of the document sought. It is suggested that at least 15 days be provided for requests made in the continental United States, and no more than 30 days for other locations, before the attempt is deemed unsuccessful. The practitioner needs to be notified and needs to assist VA in obtaining the necessary documentation through a secondary source. Examples of secondary sources include, but are not limited to: web verifications sources that do not meet appropriate guidelines; documentation from another source that claims to have verified the credential; and, as a final effort, an authenticated copy of the credential.

e. **Educational Credentials**

(1) **Verification of Educational Credentials**

(a) For health care professionals who are requesting clinical privileges, primary source verification of all residencies, fellowships, advanced education, clinical practice programs, other clinical training programs, etc., from the appropriate program director or school is required. If a physician or dentist participated in an internship(s) equivalent to the current residency years PG 1, 2, and 3, it is necessary to obtain primary source verification of the internship(s). Enrollment in any portion of an accredited training program (even if incomplete) must be reported. If an accredited stand-alone internship was completed before entering into the additional years of a residency program, both the internship and residency program must be separately verified. Any fees charged by institutions to verify education credentials are to be paid by the facility.

(b) For foreign medical school graduates, facility officials must verify with the Educational Commission for Foreign Medical Graduates (ECFMG) that the applicant has met requirements for certification, if claimed. The ECFMG is not applicable for graduates from Canadian or Puerto Rican medical schools. Documentation of completion of a “Fifth Pathway” may be substituted for ECFMG certification. Additionally, TJC accepts the primary source verification of ECFMG for foreign medical school graduation. Documentation of this verification must meet the requirements of this policy.

(c) If it is not possible to verify education, all efforts to verify education must be documented, e.g., the school has closed, the school is in a foreign country and no response can be obtained, or for other reasons. In any case, facility officials must verify and document that candidates meet appropriate VA qualification standard educational requirements prior to appointment as an employee. **NOTE:** *VA medical treatment facilities are encouraged to consider additional information concerning the education of the applicant from other authoritative sources.*



(d) Applicants are required to provide information on all educational and training experiences, including all gaps greater than 30 days, since graduation from the qualifying education degree. Primary source verification must be sought on medical, dental, professional school graduation, and all residency(ies) and fellowship(s) training, as well as internships for non-physician and non-dentist applicants.

(e) An educational institution may designate an organization as its agent for primary source verification for the purposes of credentialing. The verification from the agent is acceptable (e.g., National Student Clearinghouse). Documentation of this designation needs to be on file.

(f) For other health care practitioners, at a minimum, the level of education that is the entry level for the profession or permits licensure must be verified, as well as all other advanced education used to support the granting of clinical privileges, if applicable (e.g., for an APRN, both the qualifying degree for the registered nurse (RN) and the advanced education must be verified).

(g) Primary source verification of other advanced educational and clinical practice programs is required if the applicant offers this credential(s) as a primary support for requested specialized clinical privileges.

(2) **Educational Profile for Physicians.** Facilities may obtain, from the American Medical Association (AMA) or the American Osteopathic Association (AOA) Physician Database, a profile listing of all medical education a physician candidate has received in this country. These data sources contain other information for follow-up, as necessary.

(a) The AMA Physician Masterfile is a TJC-designated equivalent for primary source verification requirements for physicians' and osteopaths' United States education, residency, and fellowship training.

(b) The AOA Physician Database is a designated equivalent for:

1. Pre-doctoral education accredited by the AOA Bureau of Professional Education,
2. Post-doctoral education approved by the AOA Council on Postdoctoral Training, and
3. Osteopathic Board certification.

(c) In instances where these profiles do not stipulate primary source verification was obtained, the facility must pursue that verification, if required by this Handbook.

(d) If a VA facility elects to use the profile, any associated fee is borne by the facility. Nothing in this Handbook regarding the AMA Physician Profile or AOA Osteopathic Physician Profile alters Human Resources Management's documentation requirements for employment.

(3) **Filing.** Verification of all education and training is filed in the appropriate portion of VetPro.

f. **Verifying Specialty Certification**

(1) **Physician Service Chiefs.** Physician Service Chiefs must be certified by an appropriate specialty board or possess comparable competence. For candidates not board-certified, or board certified in a specialty(ies) not consistent with the assignment, the medical staff's Executive Committee of the Medical Staff affirmatively establishes and documents, through the privilege delineation process, that the person possesses comparable competence. If the Service Chief is not board certified, the Credentialing and Privileging file must contain documentation that the individual has been determined to be equally qualified based on experience and practitioner specific data. Appointment of Service Chiefs without board certification must comply with VA Handbook 5005 for these appointments, as appropriate.

(2) Verification must be from the primary source by direct contact or other means of communication with the primary source, such as by the use of a public listing of specialists in a book or Web site, or other electronic medium as long as the listing is maintained by the primary source and there is no disclaimer regarding authenticity. If listings of specialists are used to verify specialty certification, they must be from recently issued copies of the publication(s), and include authentic copies of the cover page indicating publication date and the page listing the practitioner. This information must be included in the practitioner's folder (electronic or paper) as follows:

(a) **Physicians.** Board certification may be verified through the Official American Board of Medical Specialists (ABMS) Directory of Board Certified Medical Specialists, an acceptable Internet verification, or by direct communication with officials of the appropriate board. A letter from the board addressed to the facility is acceptable for those recently certified. The electronic matching through VetPro is primary source verification because it is performed through an electronic version of Official ABMS Directory of Board Certified Medical Specialists. Osteopathic board certification may be verified through the AOA Physician Database. Copies of documents used to verify certification are to be filed in the Official Personnel Folder and in the credentialing and privileging file. **NOTE:** *The address and telephone number of the board may be obtained from the latest Directory of Approved Residency Programs published by the Accreditation Council for Graduate Medical Education.*

(b) **Dentists.** Board certification may be verified by contacting the appropriate Dental Specialty Board. **NOTE:** *Addresses of these boards may be obtained from the American Dental Association (ADA).*

(c) **Podiatrists.** The following three organizations are currently recognized by the House of Delegates, American Podiatric Medical Association, and VA: the American Board of Podiatric Surgery, the American Board of Podiatric Orthopedics, and the American Board of Podiatric Public Health. **NOTE:** *Addresses of these boards may be obtained from the latest American Podiatric Directory.*

(d). **Other Occupations.** Board certification and other specialty certificates must be primary source verified by contacting the appropriate board or certifying organization.

(3) **Evidence of Continuing Certification.** Board certification and other specialty certificates, which are time-limited or carry an expiration date, must be reviewed and documented prior to expiration.

(4) **Filing.** Verification of specialty certification is filed in the Board Certification portion of VetPro.

g. **Licensure**

(1) **Requirement for Full, Active, Current, and Unrestricted Licensure.** Applicants being credentialed in preparation for applying for clinical privileges must possess at least one full, active, current, and unrestricted license that authorizes the licensee to practice in the state of licensure and outside VA without any change being needed in the status of the license. **NOTE:** *For new appointments after a break in service, all licenses active at the time of separation need to be primary source verified for any change in status.*

(2) **Qualification Requirements of Title 38 United States Code (U.S.C.) 7402(f).** Applicants being credentialed for a position identified in 38 U.S.C. 7402(b) (other than a Director) for whom State licensure, registration, or certification is required and who possess or have possessed more than one license (as applicable to the position) are subject to the following provisions:

(a) Applicants and individuals appointed on or after November 30, 1999, who have been licensed, registered, or certified (as applicable to such position) in more than one State and who had such license, registration, or certification revoked for professional misconduct, professional incompetence, or substandard care by any of those States, or voluntarily relinquished a license, registration or certification in any of those States after being notified in writing by that State of potential termination for professional misconduct, professional incompetence, or substandard care, are not eligible for appointment, unless the revoked or surrendered license, registration, or certification is restored to a full and unrestricted status. **NOTE:** *Covered licensure actions are based on the date the credential was required by statute or the position's qualification standards. For example, if VA first required the credential in 1972, the individual lost the credential in 1983, and the individual applies, or was appointed, to VA after November 30, 1999, the individual is not eligible for VA employment in the covered position, unless the lost or surrendered credential is restored to a full and unrestricted status. However, if the individual lost the credential in 1970, before it was a VA requirement, eligibility for VA employment would not be affected provided the individual possesses one full and unrestricted license as applicable to the position (see App. B for list of occupations, job series, type of credential, and date first required by VA).*

(b) Individuals who were appointed before November 30, 1999, who have maintained continuous appointment since that date and who are identified as having been licensed, registered, or certified (as applicable to such position) in more than one State and, on or after November 30, 1999, have had such license, registration, or certification revoked for professional misconduct, professional incompetence, or substandard care by any of those States, or who voluntarily relinquished a license, registration, or certification in any of those States after being notified in writing by that State of potential termination for professional misconduct,

professional incompetence, or substandard care, are not eligible for continued employment in such position, unless the revoked or surrendered license, registration, or certification is restored to a full and unrestricted status. **NOTE:** *Individuals who were appointed prior to November 30, 1999, and have been on continuous appointment since that date are not disqualified for employment by any license, registration, or certification revocations or voluntary surrenders that predate November 30, 1999, provided they possess one full and unrestricted license as applicable to the position.*

(c) Where a license, registration, or certification (as applicable to the position) has been surrendered, confirmation must be obtained from the primary source that the individual was notified in writing of the potential for termination for professional misconduct, professional incompetence, or substandard care. If the entity verifies that a written notification was provided, the individual is not eligible for employment unless the surrendered credential is fully restored.

(d) Where the State licensing, registration, or certifying entity fully restores the revoked or surrendered credential, the eligibility of the practitioner for employment is restored. These individuals would be subject to the same employment process that applies to all individuals in the same job category who are entering the VA employment process. In addition to the credentialing requirements for the position, there must be a complete review of the facts and circumstances concerning the action taken against the State license, registration, or certification and the impact of the action on the professional conduct of the applicant. This review must be documented in the licensure portion of VetPro.

(e) This Handbook applies to licensure, registration, or certification requirements, as applicable, to any practitioner credentialed in accordance with this Handbook.

(3) When a practitioner enters into an agreement (disciplinary or non-disciplinary) with a SLB to not practice the occupation in a State, the practitioner is required to notify VA of the agreement. VA must obtain information concerning the circumstances surrounding the agreement. This includes information from the primary source of the specific written notification provided to the practitioner, including, but not limited to: notice of the potential for termination of licensure for professional misconduct, professional incompetence, or substandard care. If the entity verifies that a written notification was provided, all associated documentation must be obtained and incorporated into the Credentialing and Privileging file and VetPro. The practitioner must be afforded an opportunity to explain, in writing, the circumstances leading to the agreement. Facility officials must evaluate the individual's explanation of specific circumstances in conjunction with the primary source information, and related to the action taken by the SLB. The practitioner's explanatory statement is to be documented in the Supplemental Attestation Questions. Consultation needs to be sought from the VISN CMO and this consultation must be thoroughly documented in the Credentialing and Privileging file and VetPro.

**NOTE:** *It may be necessary to obtain a signed VA Form 10-0459, Credentialing Release of Information Authorization, request from the practitioner, requesting the State licensing board to disclose to VA all malpractice judgments and disciplinary actions as well as all open investigations and outstanding allegations and investigations. Failure by the practitioner to sign VA Form 10-0459 may be grounds for disciplinary action or decision not to appoint.*

(4) There may be instances where actions have been taken against an applicant's license for a clinically-diagnosed illness. Those applicants are eligible for appointment where they are acknowledged by the licensing, registering, or certifying entity as stable, and the licensure action did not involve substandard care, professional misconduct, or professional incompetence, and the license, certificate, or registration is fully restored. A thorough analysis of the information obtained from the entity must be documented, signed by the appropriate reviewers and approving officials, and filed in the licensure section of the Credentialing and Privileging Folder.

**NOTE:** *Questions concerning applicants who may qualify for appointment under the Rehabilitation Act of 1974, need to be referred to Regional Counsel.*

(5) **Exceptions to Licensure.** As part of the credentialing process, the status of an applicant's licensure and that of any required or claimed certifications must be reviewed and primary source verified. Except as provided in VA Handbook 5005, Part II, Chapter 3, Section B, subparagraph 14b, all LIPs must have a full, active, current, and unrestricted license to practice in any State, Territory, or Commonwealth of the United States, or in the District of Columbia. The only exceptions provided in VA Handbook 5005 are:

(a) An individual who has met all the professional requirements for admission to the State licensure examination and has passed the examination, but who has been issued a State license which is limited on the basis of non-citizenship or not meeting the residence requirements of the State.

(b) An individual who has been granted an institutional license by the State which permits faculty appointment and full, unrestricted clinical practice at a specified educational institution and its affiliates, including the VA health care facility; or, an institutional license which permits full, unrestricted clinical practice at the VA health care facility. This exception is only used to appoint an individual who is a well-qualified, recognized expert in the individual's field, such as a visiting scholar, clinician, and/or research scientist, and only under authority of 38 U.S.C. 7405. It may not be used to appoint an individual whose institutional license is based on action taken by a SLB.

(c) An individual who has met all the professional requirements for admission to the State licensure examination and has passed the examination, but who has been issued a time-limited or temporary State license or permit pending a meeting of the SLB to give final approval to the candidate's request for licensure. The license must be active, current, and permit a full, unrestricted practice. Appointments of health care professionals with such licenses must be made under the authority of 38 U.S.C. 7405 and are time-limited, not to exceed the expiration date of licensure.

(d) A resident who holds a license which geographically limits the area in which practice is permitted or which limits a resident to practice only in specific health care facilities, but which authorizes the individual to independently exercise all the professional and therapeutic prerogatives of the occupation. In some States, such a license may be issued to residents in order to permit them to engage in outside professional employment during the period of residency training. The exception does not permit the employment of a resident who holds a license which is issued solely to allow the individual to participate in residency training. Physician residents in



accredited residency programs are not to be privileged as LIPs, regardless of their license type, unless they have already completed a core residency program as required for board eligibility such as Internal Medicine, Surgery, etc., and hold a valid, full, current, and unrestricted license.

**NOTE:** *There may be changes in State licensure requirements and administrative delay by SLBs in processing renewal applications for licensure. For information on these items see VA Handbook 5005, Part II, Chapter 3, Section B, subparagraphs 13f and 13g.*

(6) SLBs may restrict the license of a practitioner for a variety of reasons. Among other restrictions, an SLB may:

(a) Suspend the licensee's ability to independently prescribe controlled substances or other drugs; or

(b) Selectively limit one's authority to prescribe a particular type or schedule of drugs; or

(c) Accept one's offer or voluntary agreement to limit the authority to prescribe, or provide an "inactive" category of licensure. **NOTE:** *In such cases, the license must be considered restricted for VA purposes, regardless of the official SLB status.*

(7) Some states authorize a grace period after the licensure and/or registration expiration date, during which an individual is considered to be fully licensed and/or registered whether or not the individual has applied for renewal on a timely basis. Facility officials will not initiate separation procedures for failure to maintain licensure or registration on a practitioner whose only license and/or registration has expired if the State has such a grace period and considers the practitioner to be fully and currently licensed and/or registered.

(8) **Physician Applicants.** Physician applicants, including physician residents who function outside of the scope of their training program, i.e., who are appointed as Medical Officer of the Day, Advanced Fellows, or in certain Chief Resident positions, must be screened with the FSMB prior to appointment. **NOTE:** *Only physician residents who have completed their core residency training (i.e., those in subspecialty fellowships) may be appointed as Medical Officer of the Day. Residents (including Chief Residents and what are commonly called 'fellows') may only be appointed in areas for which they have met the training requirements for board eligibility and may not be appointed as LIPs in areas in which they are currently training (see VHA Handbook 1400.04).*

(a) The FSMB is a national non-profit organization representing the 70 medical boards of the United States and its territories. The FSMB's Federation Physician Data Center is a central repository for formal actions taken against physicians by SLBs, disciplinary boards, or similar official sources.

(b) The Screening with the FSMB must be performed through VetPro. Once education has been verified in VetPro, the query can be electronically submitted. Responses are received by VetPro and displayed on the License screen. **NOTE:** *See Appendix C for information on determining which medical staff appointments require an FSMB query.* This response identifies any formal actions taken against the physician's licenses or the FSMB Clearance Report that lists

all current and previously held medical licenses documented in the FSMB license database.

**NOTE:** *This list needs to be compared to the licenses entered by the practitioner to ensure that the practitioner has reported all current and previously held licenses.*

(c) Screening applicants with the FSMB does not abrogate the medical facility's responsibility for verifying current and previously held medical licenses with the SLB(s) with the exception of subparagraphs 13o, 13p, 14e, and 14f.

(d) Appointment to the medical staff and granting of clinical privileges is not complete until screening against the FSMB Disciplinary Files is documented in VetPro. It must be documented in VetPro that information obtained through screening against the FSMB Disciplinary Files is verified through the primary source and that this information has been considered during the appointment process. If additional information is needed from the practitioner in response to this information, that must be obtained through, and documented in VetPro.

(e) Those practitioners who were screened against the FSMB Disciplinary Files by VA Central Office in 2002, or subsequent to this date were screened through VetPro, are placed in VHA's FSMB Disciplinary Alerts Service. Practitioners entered into the VHA's FSMB Disciplinary Alerts Service are continuously monitored. Orders reported to the FSMB from licensing entities, as well as the Department of Health and Human Services (DHHS) OIG and the Department of Defense (DOD), initiate an electronic alert that an action has been reported to VHA's Credentialing and Privileging Program Director.

1. The registration of practitioners into this system is based on these queries and only on these queries.

2. This monitoring is on-going for registered practitioners.

3. Alerts received by VHA's Credentialing and Privileging Program Director must be forwarded to the appropriate VA facility for primary source verification and appropriate action. The disciplinary information that pertains to the practitioner can then be downloaded and forwarded to the appropriate facility for review and inclusion in the practitioner's credentials file.

4. Facility credentialing staff must obtain primary source information from the SLB for all actions related to the disciplinary alert. Complete documentation of this action, including the practitioner's statement, is to be scanned into VetPro before filing in the credentials file. Medical staff leadership must review all documentation to determine the impact on the practitioner's continued ability to practice within the scope of privileges granted. This review must be completed within 30 days of the notice to the facility staff of the alert and completely documented in VetPro.

5. Practitioner names must be removed from the VHA FSMB Disciplinary Alerts Service when the practitioner file is inactivated in VetPro, or when the practitioner's appointment lapses in VetPro.

**(9) Appointment of Candidates with Previous or Current Adverse Action Involving Licensure.** Physicians and dentists, or other licensed practitioners, who have had a license or



licenses restricted, suspended, limited, issued and/or placed on probationary status, or denied upon application, may be appointed under the appointment procedures that apply to other physicians, dentists, or other health professionals.

(a) Officials included in the appointment process are to thoroughly review and document the review of all SLB documentation (findings of fact detailing the basis for the action against the applicant's license, stipulation agreements, consent orders, and final orders), as well as the applicant's subsequent professional conduct and behavior before determining whether the applicant can successfully serve as a physician, dentist, or other health care practitioner in VA.

(b) To be eligible for appointment, an applicant or employee must meet current legal requirements for licensure (see 38 U.S.C. 7402(b) and (f), and preceding subparagraphs 13g(1) and 13g(2)).

(c) If action was taken against the applicant's sole license, or against all the applicant's licenses, a review by the Chief, Human Resources Management Service, or the Regional Counsel, is necessary to determine whether the applicant meets VA's licensure requirements. Documentation of this review must include the reason for the review, the rationale for conclusions reached, and the recommended action; all this must be filed in the appropriate section of VetPro.

(d) Subject to the restrictions in preceding subparagraphs 13g(2), those health care professionals who have a current, full and unrestricted license in one or more States, but who currently have or have ever had a license, registration, or certification restricted, suspended, limited, issued and/or placed on probational status, or denied upon application, must not be appointed without a thorough documented review. The credentials file must be reviewed with Regional Counsel, or designee, to determine if the practitioner meets appointment requirements. Documentation of this review must include the reasons for the review, the rationale for the conclusions reached, and the recommended action. The review and the rationale for the conclusions must be forwarded to the VISN CMO for concurrence and approval of the appointment. All associated documentation must be filed in the appropriate section of VetPro.

#### **(10) Verification with SLB(s)**

(a) Verification of the license can be made through a letter or by telephone and documented on a report of contact. Electronic means of verification are also acceptable, as long as the site is maintained by the primary source and there is no disclaimer regarding authenticity.

(b) If the State is unwilling to provide primary source verification of licensure or requested information subsequent to written request, the facility must document the State's specifics of the refusal and secure an authenticated copy of the license from the applicant. If the reason for the SLB's refusal is payment of a fee, the facility needs to pay the fee if the review is for initial appointment.

**NOTE:** *Although credentialing is required for PAs, licensure is not required for employment, so verification of licensure is only required if claimed.*

(c) **Filing.** Verification of licensure and/or registration must be filed in the Licensure portion of VetPro.

h. **Drug Enforcement Agency (DEA) Registration and Controlled Dangerous Substance (CDS) Certification.** Where a practitioner's State of licensure requires individual DEA certification in order to be authorized to prescribe controlled substances, the practitioner may not be granted prescriptive authority for controlled substances without such individual DEA certification.

(1) **Background.** Physicians, dentists, and certain other professional practitioners may apply for and be granted renewable certification by the Federal and/or State DEA and/or CDS, to prescribe controlled substances as part of their practice. Certification must be verified for individuals who claim on the application form to currently hold or to have previously held DEA and/or CDS certification.

(2) **Application.** Each applicant possessing a DEA/CDS certificate must document information about the current or most recent DEA certificate on the appropriate VA application form. Any applicant whose DEA/CDS certification (Federal and/or State) has ever been revoked, suspended, limited, restricted in any way, or voluntarily or involuntarily relinquished, or not renewed, is required to furnish a written explanation at the time of filing the application and at the time of reappraisal.

(3) **Restricted Certificates.** A State agency may obtain a voluntary agreement from an individual not to apply for renewal of certification, or may decide to disapprove the individual's application for renewal as a part of the disciplinary action taken in connection with the individual's professional practice. While there are a number of reasons a license may be restricted which are unrelated to DEA and/or CDS certification, an individual's State license is considered restricted or impaired for purposes of VA practice if a SLB has:

- (a) Suspended the person's authority to prescribe controlled substances or other drugs;
- (b) Selectively limited the individual's authority to prescribe a particular type or schedule of drugs; or
- (c) Accepted an individual's offer for voluntary agreement to limit authority to prescribe.

(4) **DEA Verification**

(a) A copy of the current Federal DEA certification must be physically seen prior to appointment and reappointment. Automatic verification of Federal DEA certification can be performed in VetPro when a match can be made against the current Federal DEA certification information maintained in VetPro and electronically updated monthly. If verification cannot be made electronically, an authenticated copy of the DEA certificate must be entered into VetPro.

(b) Verification of a State DEA or CDS certificate can be made through a letter or by telephone and documented on a report of contact. Electronic means of verification are also acceptable as long as the site is maintained by the primary source and there is a disclaimer

regarding authenticity. If the State is unwilling to provide primary source verification, the facility must document the State's refusal and secure an authenticated copy of the license from the applicant. If the reason for the State's refusal is payment of a fee, the facility needs to pay the fee if the review is at the time of initial appointment or reappointment. This documentation must be filed in the State CDS section of VetPro. **NOTE:** *For new appointments after a break in service, any Federal or State DEA certification active at the time of separation must be verified, and any change in status documented.*

i. **Employment Histories and Pre-employment References.** For practitioners requesting clinical privileges, at least three references must be obtained, including at least one from the current or most recent employer(s) or institution(s) where the applicant holds or held privileges.

(1) For any candidate whose most recent employment has been private practice for whom employment histories may be difficult to obtain, VA facility officials must contact any institution(s) where clinical privileges are and/or were held, professional organizations, references listed on the application form, and/or other agencies, institutions, or persons who would have reason to know the individual's professional qualifications.

(2) VA Form Letter 10-341a, Appraisal of Applicant, the reference letter printed from VetPro, or any other acceptable reference letter may be used to obtain references. Additional information may be required to fully evaluate the educational background and/or prior experiences of an applicant. Initial and/or follow-up telephone or personal contact with those individuals having knowledge of an applicant's qualifications and suitability are encouraged as a means of obtaining a complete understanding of the composite employment record.

(a) All references must be documented in writing. Written records of telephone or personal contacts must include the name of the person contacted, that person's position and title, the date of the contact, a summary of the specific information provided, the name of the organization (if appropriate), and the reason why a telephone or personal contact was made in lieu of a written communication. Reports of contact are to be filed with other references in the Official Personnel Folder or, for Title 38 employees who have personnel folders, in the Merged Records Personnel Folder (MRPF) and in VetPro.

(b) For applicants requesting clinical privileges, the facility needs to send a minimum of two requests to verify that the practitioner's currently held or most recently held clinical privileges are (or were) in good standing with no adverse actions or reductions for the specified period. For those health care professionals who have recently completed a training program, one reference needs to be from the Program Director attesting to the individual's competency and skill. For those applicants with previous VA experience, the last two VA assignments or all VA assignments in the last 5 years, whichever is longer, must be verified. VA facilities must respond to all requests from other VA facilities related to the practitioner's performance and competency within VA. These responses need to include not only information on the type and length of appointment, but also an authoritative response on the individual's scope and level of performance. **NOTE:** *Although there is no specific requirement for how many years of personal history is required, work experience, and previous employment is to be verified, the facility is to make a reasonable attempt to verify all experience that is relevant to the privileges being*

*requested. In many instances this could be many years ago if the practitioner has been in practice for a long period of time.*

(3) Ideally, references need to be from authoritative sources, which may require that facility officials obtain information from sources other than the references listed by the applicant. References need to contain specific information about the individual's scope of practice and level of performance appropriate to the occupation for which the applicant is being considered. For example, information on:

(a) The number and types of procedures performed, range of cases managed, appropriateness of care offered, outcomes of care provided, etc.

(b) The applicant's medical and clinical knowledge, interpersonal skills, communication skills, clinical judgment, technical skills, and professionalism as reflected in results of quality improvement activities, peer review, and/or references, as appropriate.

(c) The applicant's health status in relation to proposed duties of the position and, if applicable, to clinical privileges being requested.

(4) Employment information and references are filed in Section V of the Credentialing and Privileging folder and the appropriate portion of VetPro.

j. **Health Status.** All applicants and employees, regardless of type of appointment, must have a new appointment after a break in service. They are required to declare on the appropriate health status form that there are no physical or mental health conditions that would adversely affect one's ability to carry out requested responsibilities. This requirement also applies to all who are required to be credentialed in accordance with this policy.

(1) This declaration of health must be confirmed by a physician designated by, or acceptable to, the facility, such as the employee health physician or physician supervisor from the individual's previous employment. Confirmation, at a minimum, is to be in the form of a countersignature by the confirming physician. The confirming physician may not be related to the applicant by blood or marriage. **NOTE:** *Additional information may be sought from appropriate source(s), if warranted.*

(2) All references must be queried as to the applicant's physical and mental capability to fulfill the requirement of the clinical privileges being sought.

(3) The documentation of health and relevant supporting information must be filed in the Personal Profile Screen of VetPro.

k. **Malpractice Considerations**

(1) **Applicants.** VA application forms, or supplemental forms, require applicants to give detailed written explanations of any involvement in administrative, professional, or judicial proceedings, including Federal tort claims proceedings, in which malpractice is, or was, alleged. If an applicant has been involved in such proceedings, a full evaluation of the circumstances

must be made by officials participating in the credentialing, selection, and approval processes prior to making any recommendation or decision on the candidate's suitability for VA appointment.

(2) **Employees and Other Returning Practitioners.** At the time of initial hire, a new appointment after a break in service, or reappraisal, each employee or returning practitioner (e.g., contractor) is asked to list any involvement in administrative, professional, or judicial proceedings, including Tort claims, and to provide a written explanation of the circumstances, or change in status. A review of clinical privileges, as appropriate, must be initiated if clinical competence issues are involved. The information provided by the individual must be filed in the Supplemental Attestation Section of the VetPro file.

(3) **Primary Source Information.** Efforts must be made to obtain primary source information regarding the issues involved and the facts of the cases. The Credentialing and Privileging folder must contain an explanatory statement by the practitioner and evidence that the facility evaluated the facts regarding resolution of the malpractice case(s), as well as a statement of adjudication by an insurance company, court of jurisdiction, or statement of claim status from the attorney. A good faith effort to obtain this information must be documented by a copy of the refusal letter or report of contact.

(4) **Evaluation of Circumstances.** Facility evaluating officials must consider VA's obligation as a health care practitioner to exercise reasonable care in determining that health care professionals are properly qualified, recognizing that many allegations of malpractice are proven groundless.

(a) Facility officials must evaluate the individual's explanation of specific circumstances in conjunction with the primary source information related to the payment in each case. The practitioner's explanatory statement is to be documented in the Supplemental Attestation Questions. A practitioner's statement included in the NPDB-HIPDB report does not satisfy the need for the practitioner to provide an explanation.

(b) This review must be documented and filed in the credentialing and privileging file. Reasonable efforts must be made to ensure that only health care professionals who are well-qualified to provide patient care are permitted to do so.

(c) NPDB-HIPDB reports contain information regarding any malpractice payment made on behalf of the practitioner. This information is considered a secondary source and does not meet the standard of primary source verification. Primary source verification must be obtained on this information from the appropriate sources.

**NOTE:** *Questions concerning legal aspects of a particular case need to be directed to the Regional Counsel or General Counsel.*

**1. National Practitioner Data Bank (NPDB)-Health Integrity and Protection Data Bank (HIPDB) Screening and Monitoring**

(1) Proper screening through the NPDB-HIPDB is required for applicants, including: physician residents who function outside of the scope of their training program as licensed independent practitioners, (i.e., those appointed as Medical Officer of the Day, Advanced Fellows, or appointed to certain Chief Resident positions); all members of the medical staff and other health care professionals who hold clinical privileges, who are, or have ever been, licensed to practice their profession or occupation in any job title represented in the NPDB and HIPDB Guidebooks; or who are required to be credentialed in accordance with this policy. The NPDB-HIPDB is a secondary flagging system intended to facilitate a comprehensive review of health care practitioners' professional credentials. The information contained in the NPDB-HIPDB is intended to direct discrete inquiry into, and scrutiny of, specific areas of a practitioner's licensure, professional society memberships, medical malpractice payment history, Federal health care program exclusion status, and record of clinical privileges. The information received in response to an NPDB-HIPDB query is to be considered together with other relevant data in evaluating a practitioner's credentials; it is intended to augment, not replace, traditional forms of credentials review. NPDB-HIPDB screening is required prior to appointment, including reappointment and transfer from another VA facility, whether or not VA requires licensure for appointment, reappointment, or transfer. This screening must be accomplished by enrolling the practitioner in the NPDB-HIPDB CQ. The NPDB-HIPDB CQ provides on-going monitoring of health care practitioners.

***NOTE:*** All practitioners must be enrolled in the NPDB-HIPDB CQ within 30 days of the availability to do so through VetPro regardless of their current appointment status.

(a) After initial enrollment, each facility is required to renew the enrollment for each practitioner in the NPDB-HIPDB CQ on, or before, the expiration of the annual enrollment; and

(b) To confirm enrollment of practitioners in the NPDB-HIPDB CQ system through review of practitioner names from VetPro against NPDB-HIPDB CQ.

(c) If currently detailed to another VA facility or serving another facility as a consultant, the receiving facility must enroll the practitioner in the NPDB-HIPDB CQ, in addition to the main facility.

(2) These procedures apply to all the VHA physicians, dentists, and other health care practitioners who are appointed to the medical staff or who hold clinical privileges whether utilized on a full-time, part-time, intermittent, consultant, attending, WOC, on-station fee basis, on-station scarce medical specialty contract, or on-station sharing agreement basis.

***NOTE:*** The requirements to enroll and monitor practitioners through the NPDB-HIPDB CQ does not apply to trainees other than those who function as staff outside the scope of their training program; i.e., residents who serve as Medical Officers of the Day, Advanced Fellows, or in certain Chief Resident positions.



(3) VetPro maintains evidence of query submission and response received, as well as any reports obtained in response to the query, and it meets the NPDB-HIPDB requirement.

(4) Because the NPDB-HIPDB is a secondary information source, any reported information must be validated by appropriate VA officials with the primary source, i.e., SLB, health care entity, malpractice payer to include, but not limited to, the circumstances for payment (e.g., payment history in and of itself is not sufficient).

(5) Screening applicants and appointees with the NPDB-HIPDB and enrollment in the NPDB-HIPDB CQ does not abrogate the COS's and appropriate Service Chief's responsibility for verifying all information prior to appointment, privileging and/or re-privileging, or proposed Human Resource Management action. **NOTE:** *All queries to the NPDB from a VA facility automatically query the HIPDB.*

(6) If the NPDB-HIPDB screen shows adverse action or malpractice reports, an evaluation of the circumstances and documentation thereof is required. This evaluation needs to follow the guidelines outlined in preceding subparagraph 13k(4) entitled "Evaluation of Circumstances," for malpractice and similarly for adverse actions. **NOTE:** *This requirement does not apply to individuals functioning within the scope of a training program.*

(7) The facility Director is the authorized representative who authorizes all submissions to the NPDB-HIPDB. Any delegation of that authority to other facility officials is to be documented, in writing, to include date of delegation, circumstances governing delegation, and title (not name) of the official who may make requests.

(8) NPDB-HIPDB enrollment and report are maintained in VetPro.

**m. Appointment and Termination of Employment under Title 5 and Title 38 Staff Relative to NPDB-HIPDB Screening**

(1) Clinically privileged and otherwise credentialed practitioners affected by this Handbook are to be appointed only after enrollment in the NPDB-HIPDB CQ has been initiated, including Temporary Appointment for Urgent Patient Care Needs (see subpar. 13p) and Expedited Appointments.

(2) If the NPDB-HIPDB screen through enrollment in the NPDB-HIPDB CQ shows action against clinical privileges, adverse action regarding professional society membership, medical malpractice payment for the benefit of the practitioner, or Federal health care program exclusion, facility officials must verify that the practitioner fully disclosed all related information required and requested by VA in its pre-employment, credentialing, and/or clinical privileging procedures.

(3) The practitioner may be employed or continued in employment only after applicable procedural requirements are met.



(4) The following are the types of reports that a facility might receive and the action, or source of guidance for action, to be used in each case. **NOTE:** *The NPDB-HIPDB reports are maintained electronically in VetPro.*

(a) If an NPDB-HIPDB report indicates any of the following actions, requirements for each action must be met.

1. Evidence of Disciplinary Action by any SLB. Documentation of thorough review by officials involved in the appointment process of information obtained from the primary source SLB taking the disciplinary action.

2. Adverse Action Taken Against Clinical Privileges. A reference from the facility(ies) or health care organization that took the action against the clinical privileges, detailing the privileges held and reason for adverse action, must be included with the credentialing information. Documentation of a thorough review by officials involved in the appointment process must be included.

3. Adverse Action Regarding Professional Society Membership. Particulars of the action must be verified with the professional society and documentation of the thorough review by officials involved in the appointment process included with credentialing information.

4. Medical Malpractice Payment for the Benefit of the Practitioner. Facility officials must evaluate the primary source information (e.g., information obtained from the insurance company or court records, etc.) and the individual's explanation of specific circumstances in each case. They may require the practitioner to provide copies of documents pertaining to the case. Questions regarding legal aspects of a particular case are to be directed to Regional Counsel. Documentation of all efforts in this regard must be a part of the credentialing information.

(b) Reviews conducted subsequent to NPDB-HIPDB reports received, either at the time of enrollment or while enrolled in the NPDB-HIPDB CQ, are to be thoroughly documented in the credentialing and privileging record (electronic and paper). Reviews include, but are not limited to, the Service Chief's as well as the preliminary review of the Executive Committee of the Medical Staff. These reviews need to consider the circumstances surrounding issues identified in the report; the practitioner's description of the issues; documentation from the primary source that reported the action; as well as the impact of these issues on the practitioners practice at the VA medical facility. Reviews initiated through receipt of a report from the NPDB-HIPDB CQ after appointment are to be completed within 90 days of receipt of the report. If the review cannot be completed in 90 days, the circumstances impeding completion must be documented at a minimum of every 30 days until completed. Facility deliberation could result in a decision to recommend:

1. Appointment, or continue in an appointed status with no change in originally anticipated action.

2. Appointment, or continue appointment status with changes, including, but not limited to, modification of clinical privileges or provision of training.

3. Non-appointment or termination.

(c) In order to ensure an appropriate review is completed in the credentialing process, a higher-level review must be performed by the VISN CMO to ensure that all circumstances, including the individual's explanation of the specific circumstances in each case, are weighed against the primary source verification and that the appointment is still appropriate. The VISN CMO review must be completed prior to presentation to the Executive Committee of the Medical Staff, for review and recommendation to continue the appointment and privileging process.

1. Circumstances requiring review by the VISN CMO are any of the following:

- a. Three or more medical malpractice payments in payment history.
- b. A single medical malpractice payment of \$550,000 or more.
- c. Two medical malpractice payments totaling \$1,000,000 or more.

**NOTE:** *This second level review is in no way an indication that practitioners who meet these criteria are more likely to have clinical practice issues.*

2. The VISN CMO, in this oversight role, may request additional information as to the specific circumstance of the report or the facility's review process. The VISN CMO review must be documented on the Service Chief's Approval screen in VetPro as an additional entry recommending appointment in these cases. Files previously reviewed with no change in information do not need to be submitted for VISN CMO review. If there is any change in information at the time of reappraisal, including those files which meet the preceding criteria, but not previously reviewed by the VISN CMO, those files must be referred to the VISN CMO for review.

(d) Once requirements for consideration and evaluation of any action reported by NPDB-HIPDB have been completed, the appointment or continued appointment decision, if appropriate, must be made following guidance in this Handbook; Title 5 policies and procedures specified in Title 5 Code of Federal Regulations (CFR) 315, 731, or 752; Federal or VA acquisition regulations; VA Directive and Handbook 0710; and VA Directive and Handbook 5021, as they apply to the category of practitioner.

(e) When any initial or subsequent NPDB-HIPDB report calls into question the professional competence or conduct of an individual appointed by VA, the facts and circumstances are to be reviewed to determine what action would be appropriate, including such actions as revision of clinical privileges, removal, etc. Such actions must be closely coordinated with the Human Resource Management Service (and in the case of contracts and sharing agreements with Acquisition and Material Management Service) to ensure that they are processed in accordance with applicable requirements.

(6) The Director, Credentialing and Privileging, or designee, must monitor the fact that a report was received by the facility until the review of the circumstances and any necessary action by facility staff is documented in VetPro. Facility staff must provide updates every 30 days until

all information is collected and any necessary action documented; however, closure is expected within 90 days of receipt of the report.

n. **Credentialing for Telehealth and Teleconsultation.** When the staff of a facility determines that telemedicine and/or teleconsultation is in the best interest of quality patient care, appropriate credentialing and privileging is required.

(1) The facility Director(s) must ensure appropriate mechanisms are in place for verifying the privileging of off-site practitioners who deliver services using telemedicine or teleconsultation and that there are appropriate resources to support these services.

(a) All practitioners treating patients using telemedicine and teleconsultation must be qualified to deliver the required level of consultation, care, and treatment with the appropriate credentialing and privileging, regardless of the technology used, and they must be credentialed and privileged to deliver that care.

(b) The practitioner providing the telemedicine and/or teleconsultation services must be credentialed and privileged in accordance with this Handbook, unless an exception is noted in this policy

(c) Sites utilizing TJC-accredited hospitals or ambulatory care organizations for telemedicine or teleconsultation may use the credentialing and privileging decision from the site providing the care:

1. The practitioner must be appropriately credentialed and privileged to provide this care at the site providing the telemedicine or teleconsultation; and

2. A formal agreement (e.g. memorandum of understanding, contract, sharing agreement, etc.) must be in place between the two organizations that requires:

a. The facility accepting these telemedicine or teleconsultation services (the site of the patient) has evidence of internal reviews of the practitioner's performance and reports any quality of care concerns to the distant site (the site of the practitioner delivering the services). At a minimum, this information includes all adverse outcomes.

b. The facility providing these services must report to the facility receiving the services any quality of care concerns that occur. At a minimum, this information includes all adverse outcomes.

**NOTE:** *In the case of an accredited ambulatory care organization, the facility must verify that the site providing the telemedicine or teleconsultation services made its credentialing and privileging decision using the process described in TJC Hospital Accreditation Manual.*

(2) **Teleconsultation.** When teleconsultation services are provided by a practitioner from a site that is not TJC accredited, the practitioner must be appointed, credentialed, and privileged at one VA medical facility site and the following processes followed.

(a) These practitioner's credentials must be shared with the facility receiving the teleconsultation services using shared access of the VetPro file.

(b) With the exception of the separate NPDB-HIPDB query discussed in subparagraph 13n(3), the practitioner providing teleconsultation services does not have to be separately appointed or credentialed at the facility or site where the patient is physically located.

(c) When the practitioner provides only teleconsultation by offering advice that supports care provided by the on-site LIP, a copy of the practitioner's current clinical privileges must be made available to the facility or site where the patient is physically located. The practitioner providing teleconsultation services does not have to be separately privileged at the facility or site where the patient is physically located.

(3) **Telemedicine.** When telemedicine services are being provided by the practitioner who directs, diagnoses, or otherwise provides clinical treatment (i.e., teleradiology, teledermatology, etc.) to a patient using a telemedicine link, and the site from which the practitioner is delivering the care is not TJC accredited, the practitioner must be appointed, credentialed, and privileged at the facility which receives the telemedicine services (patient site), as well as at the site providing the services.

(a) A separate delineation and granting of privileges must be made by the facility receiving the telemedicine services. Appropriate credentialing needs to be performed by the facility receiving the telemedicine services prior to the granting of these privileges, including response to the Supplemental Attestation Questions, licensure verification, confirmation of current competency, and a NPDB-HIPDB query.

**NOTE:** *Telemedicine involves the use of technology and is therefore a modality for the delivery of existing clinical practices. As such, there are no separate or distinct privileges for telemedicine. When considering the granting of privileges at the facility where the practitioner is physically based, the general privileging process needs to include the appropriateness of using telemedicine to deliver services and this site is considered a separate site of care in the establishment of privileges. Any consideration concerning the appropriate utilization of telemedicine equipment by the practitioner needs to be considered as part of the privileging process by the facility where the practitioner is physically located.*

(b) Before a remote practitioner conducts either telemedicine and/or teleconsultation with another facility or site, the facility or site where the patient is physically located must enroll the practitioner in the NPDB-HIPDB CQ. The NPDB-HIPDB CQ registration must be renewed in accordance with credentialing and reappraisal requirements of this Handbook. If this is not done, it must be clearly documented why an NPDB-HIPDB query was not completed before the practitioner engages in patient care using telemedicine and/or teleconsultation.

#### (4) **Contracts for Telemedicine and/or Teleconsultation Services**

(a) Contracts for telemedicine and/or teleconsultation services need to require that these services be performed by appropriately-licensed individuals. Unless otherwise required by the specific contract or Federal law (such as the Federal Controlled Substances Act), contract health

care professionals must meet the same licensure requirements imposed on VA employees in the same profession whether they are on VA (Federal) property or not when providing telemedicine or teleconsultation services.

(b) Some states do not allow telemedicine and/or teleconsultation across state lines, unless the provider is licensed in the state where the patient is physically located. In these states, the clinical indemnity coverage of contract practitioners may be void, even if they are credentialed and privileged by VA. Prior to the commencement of services by the contract practitioners providing telemedicine and/or teleconsultation or remotely monitoring physiology data from Veteran patients, the State regulatory agency in the state in which the practitioner is physically located as well as the state where the patient is physically located, must be consulted. When dealing with Federal entities, additional licenses that authorize the provision of telemedicine and/or teleconsultation services in the relevant states may not be required. The opinion of the Regional Counsel needs to be sought in these matters.

o. **Expedited Appointment to the Medical Staff.** There may be instances where expediting a medical staff appointment for LIPs is in the best interest of quality patient care. This process may be incorporated into the appropriate VHA medical treatment facility Bylaws, policy, or procedures for expediting the medical staff appointment.

(1) The credentialing process for the Expedited Appointment to the Medical Staff cannot begin until the LIP completes the credentials package, including, but not limited to, a complete application; therefore, the practitioner must submit this information through VetPro and documentation of credentials must be retained in VetPro.

(2) Credentialing requirements for this process must include confirmation of:

a. The physician's education and training (which, if necessary, can be accomplished in 24 hours through the purchase of the American Medical Association's Physician Profile).

b. One active, current, unrestricted license verified by the primary source State, Territory, or Commonwealth of the United States or in the District of Columbia.

***NOTE:*** *To be eligible for appointment, a practitioner must meet current legal requirements for licensure (see 38 U.S.C. 7402(b) and (f), and preceding subparagraph 13g).*

c. The declaration of health, by a physician designated by or acceptable to the facility, of the applicant's physical and mental capability to fulfill the requirement of the clinical privileges being sought.

d. Query of licensure history through the FSMB Physician Data Center with no adverse action report documented.

e. One peer reference who is knowledgeable of and confirms the practitioner's competence. This must be from the current or most recent employer(s) or institution(s) where the applicant holds or held privileges. The reference needs to be someone who would have reason to know the individual's current professional qualifications and competency.

- f. Current comparable privileges held in another institution.
- g. NPDB-HIPDB CQ registration with documentation of no match.

(3) If all credentialing elements are reviewed and no current or previously successful challenges to any of the credentials are noted; and there is no history of malpractice payment, a delegated subcommittee of the Executive Committee of the Medical Staff, consisting of at least two members of the full committee, may recommend appointment to the medical staff. Full credentialing must be completed within 60 calendar days and presented to the Executive Committee of the Medical Staff for ratification.

(4) The expedited appointment process may only be used for what are considered “clean” applications. The expedited appointment process cannot be used:

- (a) If the application is not complete (including answers to Supplemental Attestation Questions, Declaration of Health, and Bylaws Attestation); or
- (b) If there are current or previously successful challenges to licensure; or
- (c) If there is any history of involuntary termination of medical staff membership at another organization, involuntary limitation, reduction, denial, or loss of clinical privileges; or
- (d) If there has been a final judgment adverse to the applicant in a professional liability action.

(5) This recommendation by the delegated subcommittee of the Executive Committee of the Medical Staff must be acted upon by the VHA medical treatment facility Director. The 60 calendar days for the completion of the full credentialing process begins on the date of the facility Director’s signature.

(6) This process does not relieve the local VHA medical treatment facilities from reviewing the DHHS, OIG’s List of Excluded Individuals and Entities (LEIE) for information on whether a provider is excluded from receiving or directing the expenditure of Federal health care program funds for items or services the provider provides, orders, or prescribes while excluded.

(7) Expedited appointment to the medical staff process does not relieve VHA medical treatment facilities from any appointment requirements as defined by the Human Resources Management Program and acquisition requirements.

(8) For those practitioners where there is evidence of a current or previously successful challenge to any credential or any current or previous administrative or judicial action, the expedited process cannot be used and complete credentialing must be accomplished for consideration by the Executive Committee of the Medical Staff.

(9) This is a one-time appointment process for initial appointment to the medical staff and may not exceed 60 calendar days. It may not be extended or renewed. The complete appointment process must be completed within 60 calendar days of the Expedited Appointment



or the medical staff appointment is automatically terminated. The effective date of appointment is the date that the expedited appointment is signed by the Director, even though ratification of the appointment is accomplished within 60 calendar days (the effective date does not change).

p. **Temporary Medical Staff Appointments for Urgent Patient Care Needs.** *NOTE: Temporary appointments are for emergent or urgent patient care only and not to be used for administrative convenience.*

(1) Temporary medical staff appointments for urgent patient care needs may require appointment before full credentialing information has been received. Since credentialing is a key component in any patient safety program, the appointment of practitioners with less than complete credentials packages warrants serious consideration and thorough review of the available information. Examples include:

(a) A situation where a physician becomes ill or takes a leave of absence and a LIP would need to cover the physician's practice until the physician returns.

(b) A situation where a specific LIP with specific skill is needed to augment the care to a patient that the patient's current privileged LIP does not possess.

(2) The facility must use defined criteria for those instances, which may include the preceding examples, in which Temporary Appointments for Urgent Patient Care Needs are appropriate. Criteria must include the circumstances under which they will be used and the applicant criteria.

***NOTE:** It is not always possible to predict in advance what comprises an urgent patient care need or when it will occur, but facilities need to have predefined criteria that would require the use of Temporary Medical Staff Appointments for Urgent Patient Care Needs.*

(3) When there is an emergent or urgent patient care need, a temporary appointment may be made, in accordance with VA Handbook 5005, Part II, by the facility Director prior to receipt of references or verification of other information and action by a Professional Standards Board. Minimum required evidence includes:

(a) Verification of at least one, active, current, unrestricted license with no previous or pending actions;

(b) Confirmation of current comparable clinical privileges;

(c) Response from NPDB-HIPDB CQ registration with documentation of no match;

(d) Query of licensure history through the FSMB Physician Data Center with no adverse action reports documented; and;

(e) Receipt of at least one peer reference who is knowledgeable of and confirms the practitioner's competence, and who has reason to know the individual's professional qualifications;



**NOTE:** *In those cases where an application is completed prior to the Temporary Appointment for Urgent Patient Care needs, it must be a “clean” application with no current or previously successful challenges to licensure; no history of involuntary termination of medical staff membership at another organization; no voluntary limitation, reduction, denial, or loss of clinical privileges; and no final judgment adverse to the applicant in a professional liability action.*

(4) Temporary appointments must be completed in VetPro including the NPDB-HIPDB CQ registration and response, and the FSMB query and response. These appointments may not be renewed or repeated.

(5) An application through VetPro must be completed within 3 calendar days of the date the appointment is effective. This includes Supplemental Attestation Questions, a Declaration of Health, and a Release of Information. This additional information facilitates the required completion of the practitioner credentialing for these practitioners used in urgent patient care needs situations, as well as providing additional information for evaluation of the current Temporary Appointment and reducing any potential risk to patients.

(6) If the Temporary appointment is not converted to another form of medical staff appointment, complete credentialing must be completed, even if completion occurs after the practitioner’s temporary appointment is terminated or expires. At a minimum, the LIP must submit a VetPro application, and all credentials must be verified. If unfavorable information was discovered during the course of the credentialing, a review of the care provided may be warranted to ensure that patient care standards have been met.

**NOTE:** *Temporary appointments for urgent patient care needs may not exceed the length of time of the Temporary appointments (see subpar. 14e).*

q. **Credentialing for Contracted Services.** When consideration is being given to obtaining health care from other than VA staff, contracting requirements must address the credentialing and privileging for appointment in a VA medical facility.

**NOTE:** *These requirements are specific to contracts that are routinely for a period of 12 months and may have optional periods of performance associated with them. This does not apply to those contracts that are less than 12 months, temporary in nature, and with no optional periods of performance such as contracts for the services of a locum tenens practitioner.*

(1) **New Contracts.** When the Executive Committee of the Medical Staff determines there is a need for a clinical contract to deliver care on-station, the clinical Service Chief, in coordination with the Contracting Officer (CO) and the Contracting Officer’s Representative (COR), must ensure that credentialing and privileging is completed in accordance with this Handbook. A mechanism to ensure appropriate monitoring of not only the terms of the contract, but the care delivered by the contractor must be established at each facility.

(2) **Contract Modifications.** Any contract modifications will be discussed between the CO and the COR and any modifications that affect a practitioner’s appointment will be addressed in accordance with this Handbook.

(3) **Termination or Expiration of Contract.** Any clinical contract that is terminated or expires by determination of the CO must then require the termination of existing clinical privileges of the individual provider(s). The Executive Committee of the Medical Staff, chaired by the Chief of Staff, must prepare appropriate documentation for termination of clinical privileges. At no time will clinical privileges extend past the date of termination or expiration of a clinical contract.

r. **Reappraisal.** Reappraisal is the process of evaluating the professional credentials, clinical competence, and health status (as it relates to the ability to perform the requested clinical privileges) of practitioners who hold clinical privileges within the facility or are otherwise appointed to positions that require credentialing in accordance with this Handbook but are not privileged, e.g., researchers, administrative physicians, VHA Central Office staff, physician assistants, etc. The reappraisal process must include: the practitioner's statements regarding successful or pending challenges to any licensure or registration; voluntary or involuntary relinquishment of licensure or registration; limitation, reduction or loss of privileges at another hospital; loss of medical staff membership; pending malpractice claims or malpractice claims closed since last reappraisal or initial appointment; mental and physical status; and any other reasonable indicators of continuing qualification and competency. Additional information regarding current and/or changes in licensure and/or registration status (primary source verification is required at the time of expiration of the license and at the time of reappointment); active NPDB-HIPDB CQ registration and report results; peer recommendations; continuing medical education and continuing education units; and verification regarding the status of clinical privileges held at other institutions (if applicable) must be secured for review. **NOTE:** *Information from VA Form 10-2623, Proficiency Report, or VA Form 3482b, Performance Appraisal, may be used.*

(1) Health care professionals with multiple licenses, registrations, and/or certifications are responsible for maintaining these credentials in good standing and informing the Director, or designee of any changes in the status of these credentials at the earliest date after notification is received by the individual. At the time of expiration of any license, and at the time of reappraisal, prior to reappointment, the practitioner must provide a signed release of information, VA Form 10-0459, which authorizes the primary source to provide VA with written verification of requested information and to disclose information concerning each lawsuit, civil action, or other claim brought against the practitioner for malpractice or negligence; each disciplinary action taken or under consideration; any open or previously concluded investigations; any changes in the status of the license; and all supporting documentation related to the information provided. **NOTE:** *Facility staff must be cognizant of the time it takes to complete the written verification of licensure, if written verification is warranted.*

(2) If at any time, after the initial appointment, it is noted that a practitioner has a license revoked for substandard care, professional misconduct, or professional incompetence, immediate consultation with the Regional Counsel is required in order to ensure the practitioner meets current legal requirements for licensure (see 38 U.S.C. 7402(b) and (f), and subpar. 13g).

**NOTE:** *For those practitioners appointed prior to November 30, 1999, for whom it is verified that a license, registration, or certification has been previously revoked for substandard care, professional misconduct, or professional incompetence, a thorough review of the circumstances*

*must be performed and the relevance to professional conduct and clinical practice must be documented in the license portion of the credentialing and privileging folder. Consultation with Regional Counsel is encouraged in order to ensure the practitioner meets current legal requirements for licensure, registration, or certification (see 38 U.S.C. 7402(b) and (f)).*

(3) The Director is responsible for establishing a mechanism to ensure that multiple licenses, registrations, and/or certifications are consistently held in good standing or, if allowed to lapse, are relinquished in good standing.

(a) Written verification is not required of time-limited credentials at the time of expiration or reappraisal, but if sought is to be accompanied by VA Form 10-0459.

(b) For credentials that were held previously, but are no longer held or are no longer full and unrestricted, the practitioner must be asked to provide a written explanation of the reason(s) why such credentials are no longer held.

(c) The verifying official must contact the SLB(s) or issuing organization(s) to verify the reason(s) for any change.

s. **Transfer of Credentials.** When practitioners are assigned to more than one health care facility for clinical practice, the “parent” or originating facility must convey all relevant credentials information to the gaining or shared facility. This may be accomplished by forwarding an authenticated true copy of the Credentialing and Privileging folder to the receiving facility.

(1) The VetPro electronic credentials file must be shared with the gaining or shared facility. A copy of the original employment application, VA Form 10-2850, Application for Physicians, Dentists, Podiatrists, Optometrists and Chiropractors, or other appropriate appointment information needs to be provided to the gaining facility. The authenticated copy is joined with the formal application for clinical privileges and any other facility-specific forms. The gaining facility may use its own customary forms or format for notifying practitioners of their clinical appointments and documenting this information.

(2) The gaining facility must register the practitioner with the NPDB-HIPDB CQ, obtain primary source verification of all active licenses, accept the transferred credentials, appoint the practitioner, and grant the appropriate clinical privileges before the practitioner can engage in patient care.

t. **Disposition of Credentialing and Privileging Files**

(1) When a VA practitioner separates from VA practice, the Credentialing and Privileging folder must be maintained by the last facility of appointment and then retired to the VA Records Center 3 years after the practitioner separates from VA practice. **NOTE:** *The Records Officer at each facility is responsible to advise anyone regarding the disposition of records in accordance with the Records Control System (RCS) 10–1.*

(2) When a VA practitioner transfers from one VA facility to another, the original Credentialing and Privileging folder must be transferred to the gaining facility immediately upon transfer. The facility transferring the file must expire the practitioner's privileges as well as the appointment in VetPro which cancels the facility's CQ enrollment. **NOTE:** *This needs to be accomplished by a means that allows for tracking of the file through the transfer process, e.g., overnight mail or certified mail return receipt requested. These folders contain Sensitive Personal Information (SPI). Therefore, whatever means is used to transmit these folders must be in accordance with VA policy regarding transmission of SPI, and VA Directive 6609, Mailing of Sensitive Personal Information.*

(3) Credentialing and Privileging folders on applicants not selected for VA practice are to be destroyed 2 years after non-selection, or when no longer needed for reference, whichever is sooner.

(4) Electronic credentialing files in VetPro must be inactivated through the File Administration Screen at the time of separation or non-selection.

(5) Credentialing folders may be thinned if they become difficult to manage, but the backup material must be available in the facility.

## 14. PRIVILEGING

**NOTE:** *This paragraph contains the administrative and clinical requirements and procedures relating to the granting of clinical privileges, reappraisal, re-privileging, reduction and revocation of privileges.*

### a. Provisions

(1) Privileges must be facility specific. **NOTE:** *The delineation of clinical privileges must be: facility specific, setting specific, and practitioner specific.* This means that privileges can only be granted within the scope of the medical facility mission. Only privileges for procedures actually provided by the VA facility may be granted to a practitioner.

(2) Only practitioners who are licensed and permitted by law and the facility to practice independently may be granted clinical privileges.

(3) Clinical privileging is the process by which the institution grants the practitioner permission to independently provide specified medical or other patient care services, within the scope of the practitioner's license and/or an individual's clinical competence, as determined by peer references, professional experience, health status (as it relates to the individual's ability to perform the requested clinical privileges), education, training, and licensure and registration.

(4) Health professions trainees within accredited "core" training programs may not be granted clinical privileges as a LIP regardless of licensure status. They must function under the supervision of a LIP who has appropriate clinical privileges or scope of practice at all times (see VHA Handbooks 1400.1 and 1400.04).

b. **Review of Clinical Privileges.** Applicants completing application forms are required to respond to questions concerning clinical privileges at VA and non-VA facilities. A minimum of two efforts to obtain verification of clinical privileges currently, or most recently, held at other institutions is to be made and documented in writing in the Credentialing and Privileging folder. That verification at a minimum needs to indicate whether the privileges are (or were) in good standing with no adverse actions or reductions for the specified period of time. If the verification indicates that there are pending, or were previous, adverse actions or reductions for the specified period of time, the particulars of the action or reduction must be obtained and documentation of a thorough review by officials involved in the appointment process must be included with credentialing information.

c. **Procedures.** Privileges are granted according to the procedures delineated within this Handbook, which must be reflected in the facility Medical Staff Bylaws, Rules, and Regulations. Clinical privileges are granted for a period not to exceed 2 years. Clinical privileges are not to be extended beyond the period for which they were granted. The period for which the privileges are granted begins with the date the privileges are signed, dated, and approved by the facility Director. Although clinical privileges may not exceed 2 years, they also may not extend beyond the known period of the relationship. In those instances where ECMS determines there is a need for clinical services to be delivered on-station through a contract or sharing agreement for a period of time with optional periods of performance associated with it, privileges may be granted for up to 2 years. All other clinical services provided through contracts or other agreements, such as through a contract for a locum tenens practitioner, may not be granted privileges beyond the length of the known relationship, i.e., the length of the contract. The process for the renewal of clinical privileges needs to be initiated no later than 2 to 3 months prior to the date the privileges expire. ***NOTE: It is the responsibility of both the facility and the practitioner to ensure that privileges are reviewed and renewed by the expiration date in order to prevent a lapse in the practitioner's authority to treat patients. Applicants for privileges must be kept apprised of the status of their application and must be involved in clarification of issues, as appropriate.***

(1) **General Criteria.** General criteria for privileging must be uniformly applied to all applicants.

(a) Such criteria must include, at a minimum:

1. Evidence of current licensure;
2. Relevant training and/or experience;
3. Current competence and health status (as it relates to the individual's ability to perform the requested clinical privileges); and
4. Consideration of any information related to medical malpractice allegations or judgments, loss of medical staff membership, loss and/or reduction of clinical privileges, or challenges to licensure.



(b) Each Service Chief must establish additional criteria for granting of clinical privileges within the service consistent with the needs of the service and the facility as well as within the available resources to provide these services. Clinical privileges must be based on evidence of an individual's current competence. When privilege delineation is based primarily on experience, the individual's credentials record must reflect that experience, and the documentation must include the numbers, types, and outcomes of related cases, when available. For all new privileges granted, a Focused Professional Practice Evaluation (FPPE) is required. The FPPE is required for practitioners new to the facility, as well as practitioners already appointed at the facility who are requesting new privileges (see subpar. 14g).

(2) **Delineation of Privileges.** Delineated clinical privileges are an accurate, detailed, and specific description of the scope and content of patient care services for which a practitioner is qualified. Prior to granting a privilege, the resources necessary to support the requested privilege are determined to be currently available, or available within a specified period of time. Privileges granted are authorized by the facility Director and are based on these available resources and the practitioner's credentials and performance.

(a) The Service Chief is responsible for developing the criteria for the delineation of privileges for the care delivered within the individual service and ensuring that appropriate resources are available to support those privileges. The privileges are then recommended by the Executive Committee of the Medical Staff as defined in the Medical Staff Bylaws to the facility Director for approval. These criteria for the delineation and granting of privileges are to be reviewed on a regular basis as defined in the Medical Staff Bylaws, but at a minimum they are reviewed once a year in order to ensure that privileges are still appropriate with adequate resources to support them and there is no need of modification.

(b) Privileges granted to an applicant must be facility specific and based on the resources necessary to support the requested privileges as well as the procedures and types of services that are provided within the health care facility. The requirements or standards for granting privileges to perform any given procedure, if performed by more than one service, must be the same. One standard of care must be guaranteed regardless of practitioner, service, or location within the facility.

(c) The VA medical facility must delineate what clinical services will be provided and the process for granting privileges after consideration of such things including, but not limited to: resources available, support services, level of training and experience of practitioners, patient need and risk categories, and types of procedures or treatments. The process to be used must be established by the individual services and recommended by the Executive Committee of the Medical Staff. The process by which privileges are delineated must be documented as part of local VA facility bylaws. An acceptable model might combine patient needs and pertinent risk categories with specific clinical areas to produce a list of procedures by specialty and/or service area. At a minimum, consideration needs to be given to evidence of relevant training or experience, current competence, and the ability to perform the privileges. Each clinical service or specialty is responsible to follow the locally-delineated policy in defining the levels or categories of privileges being recommended for approval of the Executive Committee of the Medical Staff.



(3) **Service Specific Privileges.** Each practitioner must be assigned to, and have clinical privileges in, one clinical service and may be granted privileges in other clinical services. For example, a physician may have privileges in neurology and psychiatry, if appropriate. The exercise of clinical privileges within any service is subject to the policies and procedures of that service and the authority of that Service Chief. *In instances where a practitioner is granted privileges in more than one service, the Service Chief from all services where privileges are granted must recommend the privileges specific to that service. For example, a podiatrist who maintains privileges through Surgical Service but also staffs a clinic in the long-term care section of the facility should have privileges recommended by both the Chief of Surgery, as well as the Chief of Extended Care Service since both are responsible for ensuring adequate resources are available as well as the monitoring of the quality of care.*

(4) **Setting Specific Privileges.** Privileges are setting specific, within the context of each facility, requiring consideration of each unique setting's characteristics, such as: adequate facilities, equipment, the number and type of qualified support personnel, and resources.

(a) Each facility must decide which privileges can be performed in designated settings based on staffing, equipment availability, other support services, and other resources. Setting-specific privileges are granted based on the practitioner's qualifications, and on consideration of the procedures and types of care, treatment, and services that can be performed or provided within the proposed setting. When granted, providers should only perform the specified privileges within the designated setting. For example, privileges for elective cardioversion may only be exercised in the intensive care unit where appropriate monitoring equipment, trained staff, and support services are available.

(b) Practitioners who do not have the specified privileges for a specific setting are not to practice in that setting, even if they believe the privileges granted are comparable for that setting.

d. **Initial Privileges.** Clinical privileges must be granted for all physicians, dentists, and other health care professionals licensed for independent practice, covered by this Handbook when they are involved in patient care. The intent of this process is to ensure that all physicians, dentists, and other health care practitioners, when they are functioning independently in the provision of medical care, have privileges that define the scope of their actions, which is based on current competence within the scope of the mission of the facility, and other relevant criteria. Documentation of clinical activity (i.e., evidence that a practitioner has performed a procedure) is one component of the competency equation. The second component is whether or not the practitioner has had good outcomes in practice or when performing a procedure. The process for the requesting and granting of clinical privileges follows:

(1) Clinical privilege requests must be initiated by the practitioner. For all practitioners desiring clinical privileges, the initial application for appointment must be accompanied by a separate request for the specific clinical privileges desired by the applicant. The applicant has the responsibility to provide evidence or establish possession of the appropriate credentials, qualifications, and the clinical competency to justify the clinical privileges request.

(2) The applicant's request for clinical privileges, as well as all credentials offered to support the requested privileges, must be provided for review to the Service Chief responsible for that

particular specialty area. The Service Chief must review all credentialing information including health status (as it relates to the ability to perform the requested clinical privileges), experience, training, clinical competence, judgment, clinical and technical skills, professional references, conclusions from performance improvement activities that are not protected under 38 U.S.C. 5705, and any other appropriate information. The documentation of this review must include, at a minimum, a list of the documents reviewed and the rationale for the conclusions. The Service Chief must document (list documents reviewed and the rationale for conclusions reached) that the results of quality of care activities have been considered in recommending individual privileges and personally complete the "Service Chief's Approval" in VetPro. **NOTE:** *The Service Chief Approval must be completed by the Service Chief and no portion of this process may be delegated, including documentation in VetPro.* Upon completion of this assessment, the Service Chief makes a recommendation as to the practitioner's request for clinical privileges. The Service Chief recommends approval, disapproval, or a modification of the requested clinical privileges. This recommendation must include a FPPE which is for a limited period of time and may include direct supervision, or proctoring, by an appropriately-privileged practitioner for privileges. The FPPE is required for all providers requesting initial privileges as well as when a practitioner has had a lapse in clinical activity, or for those procedures that are high risk as defined by medical facility policy.

(3) Subsequent to the Service Chief's review and recommendation, the request for privileges, along with the appointment recommendation of the credentialing committee (if applicable as defined in the facility Medical Staff Bylaws), must be submitted to the medical staff's Executive Committee of the Medical Staff for review. The medical staff's Executive Committee of the Medical Staff evaluates the applicant's credentials, the recommendation of the Service Chief, and other available information to determine if clinical competence is adequately demonstrated to support the granting of the requested privileges. Minutes must reflect the documents reviewed and the rationale for the stated conclusion. The final recommendation of the Executive Committee of the Medical Staff is then submitted to the facility Director.

(4) Residents who are appointed, outside of their training program, to work on a fee basis as Medical Officer of the Day, Advanced Fellows, or as Chief Residents who are expected to assume intermittent Supervising Attending duties must be licensed, credentialed, and privileged for the duties they are expected to perform and meet all requirements from the Office of Academic Affiliations and other VHA policy.

(a) In this capacity, they are not working under the auspices of a training program, and must meet the same requirements as all physicians and dentists appointed at the facility. Specifically, they must have already completed the core residence training in the clinical area in which privileges are being granted. The term "resident" also includes health care professionals in advanced post-graduate education programs who are typically referred to as "fellows."

(b) Privileges granted must be commensurate with the level of training and experience of these individuals appointed outside of their training program. For example, a Nephrology Fellow may be granted privileges in Internal Medicine because training in Internal Medicine was completed prior to entry into a Nephrology Fellowship. The same Nephrology Fellow could not be granted privileges specific in Nephrology. See VHA Handbook 1400.1, Resident Supervision.

(5) Copies of current clinical privileges must be available to medical facility staff on a need-to-know basis in order to ensure practitioners are functioning within the scope of their clinical privileges. Operating rooms and intensive care units are examples of areas where staff must be aware of practitioner privileges. Copies of privileges may be given to individuals on a need-to-know basis (e.g., a Service Chief responsible for monitoring compliance with the privileges granted, or a pharmacist who verifies prescribing privileges or establishes limitations on prescribing for certain medical staff members). A mechanism needs to be established to complete this in a timely manner so current privileges are available to staff who have a need-to-know the privileges a practitioner may exercise. Privileges, like credentials, are protected by the Privacy Act and may only be made available in accordance with the Privacy Act System of Records 77VA10Q.

**NOTE:** *Practitioners performing procedures outside the scope of their privileges may be subject to disciplinary or administrative action.*

(6) The requesting and granting of clinical privileges for COSs and facility Directors must follow the procedures, as outlined for other practitioners. The request for privileges must be reviewed, and a recommendation made, by the relevant Service Chief responsible for the particular specialty area in which the COS, or Director requests privileges. When considering clinical privileges for the COS an appropriate practitioner must chair the medical staff's Executive Committee of the Medical Staff and the COS must be absent from the deliberations. The Executive Committee of the Medical Staff recommendation regarding approval of requested privileges is submitted directly to the facility Director for action. **NOTE:** *In instances where the Service Chief or Executive Committee of the Medical Staff has concerns about their ability to be objective, consultation should be sought from the VISN CMO.*

(7) The privileging of facility COS and Director desiring clinical privileges must follow the procedures as outlined for new practitioners. The approval authority for the requested privileges is to be delegated to the Associate Director, who is authorized to act as facility Director for this purpose.

(8) In those instances where a VISN CMO or Director, or other staff not directly employed by the facility (e.g., VA Central Office) is requesting clinical privileges, the process for such clinical privileges must follow the procedures, as outlined for other practitioners. The request for privileges must be reviewed, and a recommendation made, by the relevant Service Chief responsible for the particular specialty area. The Executive Committee of the Medical Staff recommendations regarding approval of requested privileges must be submitted directly to the facility Director for action.

(9) When a privileged practitioner is being considered for transfer, detail, or to serve as a consultant to another VA facility, transfer of credentials are to be accomplished as outlined in subparagraph 13r. In these instances, the practitioner must request privileges at the gaining facility and provide the facility with the required documentation. Since privileges are facility specific as well as practitioner specific, they are not transferable, the receiving facility must have the practitioner apply to the facility, complete the reappraisal process, including the verification of all time-limited credentials and a new registration with the NPDB-HIPDB CQ. The only exception to the requirement of transferring credentials is when the provider will be providing

teleconsultation services and/or telemedicine services to sites that are accredited by TJC. The process for sharing credentials for teleconsultation and/or telemedicine services must be followed as defined in subparagraph 13n.

(10) A denial of initial privileges, for whatever reason, is not reportable to the NPDB. Where it is determined, for whatever reason that the initial application and request for clinical privileges should be denied, the credentialing file, and appropriate minutes must document that a medical staff appointment is not being made and no privileges are being granted. Other documentation is at the discretion of the chairman of the committee(s) and the facility Director. A "Do Not Appoint" screen must be completed in VetPro documenting the date of the decision. This denial of initial clinical privileges does not carry with it any right to due processes.

e. **Temporary Privileges for Urgent Patient Care Needs.** Temporary privileges for health care professionals in the event of emergent or urgent patient care needs may be granted by the facility Director at the time of a temporary appointment with the completion of the appropriate credentialing as defined in subparagraph 13p. Such privileges must be based on documentation of a current State license and other reasonable, reliable information concerning training and current competence. The recommendation for temporary privileges must be made by the COS and approved by the facility Director. Temporary privileges are not to exceed 60 calendar days.

f. **Disaster Privileges.** Disaster privileges may be granted when the facility has chosen to incorporate a process for granting disaster privileges into the credentialing and privileging process defined in the Medical Staff Bylaws and the facility emergency management plan, only when the emergency management plan has been activated and the facility is unable to handle the immediate patient needs. The Medical Staff Bylaws must identify those individuals responsible for granting disaster privileges to volunteer practitioners. At a minimum the process for granting disaster privileges must include:

- (1) Identification of the individual(s) responsible for granting disaster privileges.
- (2) A description of the responsibilities of the individual(s) responsible for granting disaster privileges.
- (3) A description of how volunteer LIPs will be distinguished from those currently appointed at the facility.
- (4) A description for oversight of the performance of volunteer LIPs who are granted disaster privileges.
- (5) A description of the mechanism to manage the activities of the health care professionals who are granted disaster privileges, as well as a mechanism to readily identify these individuals.
- (6) A description of the verification process at the time disaster privileges are granted which must include:
  - (a) A current hospital photo identification card and evidence of current license to practice; or

(b) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT); or

(c) Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a Federal, State, or municipal entity.

(7) The facility determines within 72 hours of the practitioner's arrival if granted disaster privileges should continue based on its oversight of the practitioner.

(8) Primary source verification of licensure must occur as soon as the disaster is under control or within 72 hours from the time the practitioner presents to the facility, whichever comes first. If primary source verification of a practitioner's licensure cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the facility documents the reason(s) it could not be performed within 72 hours of the practitioner's arrival; evidence of the practitioner's demonstrated ability to continue to provide adequate care, treatment; and services, and evidence of the hospital's attempt to perform primary source verification as soon as possible.

(9) A specified period of time must be established under which these health care professionals granted disaster privileges may practice on these disaster privileges. This period may not exceed 10 calendar days or the length of the declared disaster, whichever is shorter. At the end of this period, the practitioner needs to be converted to Temporary Privileges defined by this policy or be relieved.

(10) A defined process must be established to ensure the verification process of the credentials and privileges of health care professionals who receive disaster privileges that begins as soon as the immediate situation is under control. This process must be identical to the process for granting Temporary Privileges and ultimately result in complete credentialing of these practitioners.

g. **Focused Professional Practice Evaluation.** FPPE is not a restriction or limitation on the practitioner to independently practice, but rather an oversight process to be employed by the facility when a practitioner does not have the documented evidence of competent performance of the privileges requested. It is a process whereby the facility evaluates the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privileges of the facility.

(1) FPPE is a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance.

(2) The FPPE typically occurs at the time of initial appointment to the medical staff, or the granting of new, additional privileges. The focused professional practice evaluation may be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high-quality patient care.



(3) The criteria for the FPPE process are to be defined in advance, using objective criteria accepted by the practitioner, recommended by the Service Chief and Executive Committee of the Medical Staff as part of the privileging process and approved by the Director. The process may include periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, or discussion with other individuals involved in the care of patients.

**NOTE:** *Failure of a practitioner to accept the criteria for the FPPE will result in new privileges not being granted or additional actions taken as appropriate, for currently privileged practitioners.*

(4) Results of the FPPE must be documented in the practitioner's provider profile and reported to the Executive Committee of the Medical Staff for consideration in making the recommendation on privileges and other considerations.

h. **Triggered Reviews.** VHA has a robust quality management and performance improvement process. The information collected and the analysis of patient care activities under this process is protected by 38 U.S.C. 5705 and may not be used during any portion of the review process for the granting of clinical privileges. The 38 U.S.C 5705-protected materials may trigger the need to perform a more in-depth review of a practitioner. The medical staff may choose to identify and approve in advance "triggers" applied to these data collections and analyses that occur in the facility that will be used to initiate a non-protected review. **NOTE:** *It is important to remember that, with very few exceptions, VHA data alone is not protected by 38 U.S.C. 5705 and can be used to populate the practitioner's profile for either a FPPE or on-going monitoring.*

(1) These triggers need to be defined locally to meet the facility's needs and, depending upon the seriousness of the identified trigger, a more in-depth review could be based on a single event or a specified number of events identified and aggregate data.

(2) The criteria that would trigger a more in-depth review must be defined in advance, and be objective, measurable, and uniformly applied to all practitioners with similar privileges.

i. **On-Going Monitoring of Privileges.** The on-going monitoring of privileged practitioners, Ongoing Professional Practice Evaluation (OPPE), is essential to confirm the quality of care delivered. This allows the facility to identify professional practice trends that impact the quality of care and patient safety. Such identification may require intervention by the medical staff leadership. Criteria-based privileges make the on-going monitoring of privileges easier for medical staff leadership. Each Service Chief should consider what medical facility, regional, state, national, and specialty standards, activities, and data are available to meet these needs. The maintenance of certification is not sufficient in and of itself. There are a number of activities such as direct observation, clinical discussions, and clinical pertinence reviews that, if documented, can also be incorporated into the on-going monitoring process. Data must be practitioner specific, reliable, easily retrievable, timely, justifiable, comparable, and risk adjusted where appropriate.

(1) The timeframe for on-going monitoring is to be defined locally. It is suggested that, at a minimum, Service Chiefs must be able to demonstrate that relevant practitioner data is reviewed



on a regular bases (i.e., at a minimum of each 6 months). Consideration may be based on a period of time or a specified number of procedures, and may consider high risk or high volume for an adjustment to the frequency.

(2) With very few exceptions, VHA data standing alone is not protected by 38 U.S.C. 5705. Its use would dictate the appropriate protections under law. Data that generates documents used to improve the quality of health care delivered or the utilization of health care resources is protected by 38 U.S.C. 5705. Data that is not previously identified as protected by 38 U.S.C. 5705 and is collected as provider-specific data could become part of a practitioner's provider profile, analyzed in the facility's defined on-going monitoring program, and compared to pre-defined facility triggers or de-identified quality management data.

(3) In those instances where a practitioner does not meet established criteria, the Service Chief has the responsibility to document these facts. These situations can occur for a number of reasons and do not preclude a Service Chief recommending the renewal of privileges, but the Service Chief must clearly document the basis for the recommendation of renewal of privileges.

(4) The Executive Committee of the Medical Staff must consider all information available, including the Service Chief's recommendation and reasons for renewal when criteria have not been met, prior to making their recommendation for the granting of privileges to the Director. This deliberation must be clearly documented in the minutes.

(5) The facility Director must weigh all information available, as well as the recommendations, in the determination of whether or not to approve the renewal of privileges and document this consideration.

j. **Reappraisal and Re-privileging**

(1) **Reappraisal.** Reappraisal is the process of reevaluating the professional credentials, clinical competence, and health status (as it relates to the ability to perform the requested clinical privileges) of practitioners who hold clinical privileges within the facility.

(a) Reappraisal for the granting of clinical privileges must be conducted for each practitioner at least every 2 years, but prior to the expiration of such privileges.

1. The reappraisal process must include:

a. The practitioner's statements regarding successful or pending challenges to any licensure or registration.

b. Voluntary or involuntary relinquishment of licensure or registration. **NOTE:** *If there is evidence of voluntary or involuntary relinquishment of licensure or registration (as applicable to the position), evidence must be obtained that the practitioner meets VA's licensure requirements (see 38 U.S.C. 7402(b) and (f), and subpar. 13g).*

c. Limitation, reduction, or loss (voluntary or involuntary) of privileges at another hospital.

d. Loss of medical staff membership.

e. Pending malpractice claims or malpractice claims closed since last reappraisal or initial appointment. **NOTE:** *If there is evidence of pending malpractice cases or malpractice cases closed since last reappraisal or initial appointment, every effort must be made and documented to obtain relevant information regarding the issues involved and the facts of the case(s). The Credentialing and Privileging file must contain an explanatory statement by the practitioner and evidence that the facility evaluated the facts regarding resolution of the malpractice case(s), as well as a statement of adjudication from the primary source to include, but not limited to: an insurance company, court of jurisdiction, or statement of claim status from the attorney. In the case of the Federal Tort Claims Act (FTCA), information on the adjudication of the case may come from the facility Risk Manager, the Regional Counsel, or the Office of Medical-Legal Affairs.*

f. Mental and physical status (as it relates to the ability to perform the requested clinical privileges); and

g. Any other reasonable indicators of continuing qualifications.

2. Additional information regarding licensure and/or registration status, NPDB-HIPDB CQ report results, peer recommendations, continuing medical education and continuing education unit accomplishments, and information regarding the status of clinical privileges held at other institutions (if applicable) must be secured for review.

a. Peer references are best obtained from those of the same discipline or profession who practice with, and know the practitioner's practice. If possible, at least one of the peer references needs to be obtained from someone of the same discipline or profession who can speak with authority on the practitioner's clinical judgment, technical skill, etc.

b. Where there is no one of the same discipline or profession with knowledge of the practitioner's practice, at least one peer reference must be obtained from a health care professional with essentially equal qualifications and comparable privileges with knowledge of the practitioner's performance and practice patterns. Careful consideration needs to be given to avoid the appearance of professional prejudice. A second peer reference can be obtained from a health care professional who has a referral relationship with the practitioner.

c. In instances where at least one peer reference cannot be obtained from a peer of the same profession or a professional with comparable privileges, assistance for the peer reference needs to be sought from the VISN CMO or VHA Program Director for the profession. **NOTE:** *Information from VA Form 10-2623, or VA Form 3482b, may be considered.*

(b) Evaluation of professional performance, judgment, and clinical and/or technical competence and skills is to be based in part on results of practitioner-specific performance improvement activities and data analysis. Ongoing reviews conducted by Service Chiefs must be comprised of activities with defined criteria that emphasize the facility's performance improvement plan, appropriateness of care, patient safety, and desired outcomes and are not protected by 38 U.S.C. 5705.

1. The individual providers' profiles may include practitioner-specific, non-38 U.S.C. 5705-protected data when applicable. For example, the practitioner-specific data may include the following information, when it is not generated as part of a 38 U.S.C. 5705-protected activity: information from surgical case or invasive procedure review; infection control reviews; drug usage evaluation; medical record review; blood usage review; pharmacy and therapeutic review; and monitoring and evaluation of quality, utilization, risk, and appropriateness of care. The relevant-practitioner-specific data in these provider profiles can be compared to de-identified aggregate data (like the blood use evaluation summary) as long as the implicit and explicit identification of other providers cannot occur. De-identified aggregate data needs to include practitioners with comparable or similar privileges.

2. Materials protected by 38 U.S.C. 5705 may not be used during any portion of the review process for the granting of clinical privileges. The 38 U.S.C 5705-protected materials may trigger the need to perform a more in-depth review; however, quality improvement information that is confidential and privileged in accordance with 38 U.S.C. 5705 may not be used for any part of the reappraisal process even in support of the privileges recommended or granted.

(c) The reappraisal process needs to include consideration of such factors as the number of procedures performed or major diagnoses treated, rates of complications compared with those of others doing similar procedures, and adverse results indicating patterns or trends in a practitioner's clinical practice. Relevant practitioner-specific data needs to be compared to the aggregate data of those privileged practitioners that hold the same or comparable privileges.

(2) **Re-privileging.** Re-privileging is the process of granting privileges to a practitioner who currently holds privileges within the facility.

(a) This process must be conducted at least every 2 years, but prior to the expiration of such privileges. Requests for privileges must be processed in the same manner as initial privileges. Practitioners must request privileges in a timely manner prior to the expiration date of current privileges. **NOTE:** *It is suggested that facilities allow a minimum of 2 to 3 months to process privilege requests.*

(b) VA medical facilities must have in place internal controls that allow for the rapid identification of who is delivering care in the facility and be able to confirm that each practitioner is appropriately credentialed and privileged. Internal controls allow for not only the identification of practitioners who are departing the facility (e.g., retirement, resignation, termination of a contract, etc.) so that privileges can be terminated in a timely manner, but also the arrival of new practitioners. No privileges can extend past the last known day of a practitioner's relationship with the facility.

(c) The Service Chief must assess a minimum of two peer recommendations and all other information that addresses the professional performance, judgment, clinical and/or technical skills, any disciplinary actions, challenges to licensure, loss of medical staff membership, changes in clinical privileges at another medical facility, health status (as it relates to the ability to perform the requested clinical privileges), and involvement in any malpractice actions. The Service Chief must document (list documents reviewed and the rationale for conclusions reached) that the results of quality of care activities have been considered in recommending

individual privileges and complete the "Service Chief's Approval" in VetPro. Upon completion of this assessment, the Service Chief makes a recommendation as to the practitioner's request for clinical privileges.

(d) The requested privileges and the Service Chief's recommendation must be presented, with the supporting credentialing, health status, and clinical competence information, to the medical staff's Executive Committee of the Medical Staff for review and recommendation. The decision of the Executive Committee of the Medical Staff must be documented (the minutes must reflect the documents reviewed and the rationale for the stated conclusion) and submitted to the facility Director, as the approving authority, for final action.

(e) Because facility mission and clinical techniques change over time, it is normal that clinical privileges may also change. The Service Chief must review, with the practitioner, the specific procedures and/or treatments that are being requested. Issues, such as documented changes in the facility mission, failure to perform operations and/or procedures in sufficient number, or frequency to maintain clinical competence in accordance with facility established criteria, or failure to use privileges previously granted, will affect the Service Chief's recommendation for the granting of new privileges, or the granting of the continuation of privileges. These actions must be considered changes and are not to be construed as a reduction, restriction, loss, or revocation of clinical privileges. Such changes must be discussed between the Service Chief and the involved practitioner.

(f) Practitioners may submit a request for modification of clinical privileges at any time. Requests to increase privileges must be accompanied by the appropriate documentation, which supports the practitioner's assertion of competence, i.e., advanced educational or clinical practice program, clinical practice information from other institution(s), references, etc. The request must be made through VetPro by opening the electronic record for re-credentialing. In addition to verifying all current credentials and competency associated with this request, active licenses must be verified and confirmation of an active NPDB-HIPDB CQ reenrollment must be made. Requests for other changes need to be accompanied by an explanatory statement(s). The request for modification of clinical privileges, supporting documents, and practitioner's Credentialing and Privileging file must be presented to the appropriate Service Chief for review. The Service Chief considers the additional information and the entire Credentialing and Privileging file before making a recommendation to the Executive Committee of the Medical Staff that includes how the new privilege(s) will be monitored through a defined FPPE. The Executive Committee of the Medical Staff then presents a recommendation to the facility Director for action.

(g) The process of reappraisal and granting new clinical privileges for facility Directors and COSs is the same as outlined in preceding paragraphs. The facility Director's or COS's request for privileges must be reviewed, and a recommendation made by the relevant Service Chief responsible for the particular specialty area in which the privileges are requested. When the COS is being considered for privileging, the COS must be absent from the Executive Committee of the Medical Staff deliberations, which an appropriate practitioner chairs. The Executive Committee of the Medical Staff recommendations related to the approval of the requested privileges must be submitted directly to the Director for action, or to the Associate Director who is authorized to act as facility Director for this purpose.

k. **Denial and Non-renewal of Privileges.** This paragraph defines procedures related to the denial or non-renewal of clinical privileges and the requirements for reporting or not reporting such denials to the NPDB.

(1) At the time of initial application and request for clinical privileges, if it is determined, for whatever reason, that the application should be denied, the credentialing file and appropriate minutes must document that a medical staff appointment is not being made and no privileges are being granted. Other documentation is at the discretion of the chairman of the committee(s) and the facility Director. A “Do Not Appoint” screen must be completed in VetPro documenting the date of this decision. This denial is not reportable to the NPDB.

(2) At the time of reappraisal and renewal of clinical privileges, privileges that are denied or not renewed based on facility resources must be documented as such in the Credentialing and Privileging file, as well as the appropriate minutes. This action is not reportable to the NPDB.

(3) For all other actions in which clinical privileges requested by a practitioner are denied or not renewed, the reason for denial must be documented. If the reason for denial or non-renewal is based on, and considered to be related to, professional incompetence, professional misconduct, or substandard care, the action must be documented as such and is reportable to the NPDB after appropriate internal VA Medical Center due process procedures for reduction and revocation of privileges, pursuant to this Handbook, are provided (see VHA Handbook 1100.17). **NOTE:** *VA reports adverse privileging actions against physicians and dentists to the NPDB (see VHA Handbook 1100.17 and 38 CFR Part 46).*

(4) Material that is obtained as part of a protected performance improvement program (i.e., under 38 U.S.C. 5705), may not be disclosed in the course of any action to reduce or revoke privileges, nor may any reduction or revocation of privileges be based directly on such performance improvement data. If such information is necessary to support a change in privileges, it must be developed through mechanisms independent of the performance improvement program, such as administrative reviews, boards of investigation, or management reviews. In these instances, the performance improvement data may have triggered the review; however, the quality improvement information is confidential and privileged in accordance with 38 U.S.C. 5705, and therefore must be rediscovered through the administrative review or investigation process.

l. **Reduction and Revocation of Privileges.** This paragraph defines policy and procedures related to the reduction and/or revocation of clinical privileges based on deficiencies in professional performance.

(1) Management officials are prohibited from taking or recommending personnel actions (resignation, retirement, reassignment, etc.) in return for an agreement not to initiate procedures to reduce or revoke clinical privileges where such action is indicated. In addition, reporting to the NPDB (including the submission of copies to SLBs) may not be the subject of negotiation in any settlement agreement, employee action, legal proceedings, or any other negotiated settlement. Such agreements or negotiations are not binding on VA and may form the basis for administrative and/or disciplinary action against the officials entering into such agreement or negotiated settlement.



(2) A reduction or revocation of privileges may not be used as a substitute for disciplinary or adverse personnel action. Where a disciplinary or adverse personnel action is warranted for a permanent full-time title 38 employee, the action against the privileges is to be incorporated into the due process procedures provided for the disciplinary or adverse personnel action.

(a) Health professions trainees functioning within the scope of their training program are not subject to disciplinary or adverse actions as defined in this policy because they are not privileged and they are fully supervised by a privileged, licensed independent practitioner.

(b) Any situation that results in a practitioner being proctored, where the proctor is assigned to do more than just observe, but rather exercise control or impart knowledge, skill, or attitudes to another practitioner ensuring that patient care is delivered in an appropriate, timely, and effective manner may constitute supervision. If this occurs after initial privileges have been granted, it is considered a restriction on the practitioner's privileges and, as such, subject to all due process requirements associated with a reduction of privilege for a physician or dentist, and is reportable to the NPDB if proctorship lasts longer than 30 days from the date the privileges are reduced or placed in a proctored status.

### (3) General Provisions

(a) These Activities may be Separate from the Reappraisal and Re-privileging process. Data gathered in conjunction with the practitioner-specific FPPE, triggered review, on-going monitoring, or the facility's performance improvement activity is an important tool for identifying potential deficiencies. Material that is obtained as part of a protected-performance improvement program (i.e., under 38 U.S.C. 5705), may not be used during the appraisal process, nor may any reduction or revocation of privileges action be based directly on such performance improvement data. If such information is necessary to support a change in privileges, it must be developed through mechanisms independent of the performance improvement program, such as a focused professional practice evaluation, an administrative review, or boards of investigation. In these instances, the performance improvement data may have triggered the review; however, the quality improvement information is confidential and privileged in accordance with 38 U.S.C. 5705, and must be rediscovered through the administrative review or investigation process.

1. Actions taken against a practitioner's privileges that are not related to professional competence or professional conduct may not be subject to these provisions. Examples of actions that may be considered as not reportable include, but are not limited to, failure to maintain licensure and failure to meet obligations of medical staff membership.

2. Medical staff appointments and privileges will not be granted for a period longer than the formal relationship with the facility as noted in this policy. For example, if a contract or appointment through Human Resources has a finite end date and there is no expectation for an optional period of performance, privileges may not be granted past the end date of the contract or appointment. If a contract or other appointment is terminated prior to expiration, privileges must be terminated since there is no legal agreement for the practitioner to be providing care. Where the contract or other appointment is terminated early based on substandard care, professional incompetence, or professional misconduct, privileges need to be revoked and a report made to



the NPDB, following appropriate due process procedures described in subparagraph 14l(5)(g). Where early termination of the contract or other appointment does not involve substandard care, professional incompetence, or professional misconduct, privileges must be terminated without regard to the due process requirements for privileging actions. This termination is not reportable to the NPDB.

(b) Reduction and Revocation of Privileges. A reduction of privileges may include restricting or prohibiting performance of selected specific procedures, including prescribing and/or dispensing controlled substances. Reduction of privileges may be time limited and/or have restoration contingent upon some condition, such as demonstration of recovery from a medically-disabling condition or further training in a particular area. Revocation of privileges refers to the permanent loss of clinical privileges. If it becomes necessary to formally reduce or revoke clinical privileges based on deficiencies in professional performance, the procedures indicated in this Handbook must be followed. Procedures for reduction and revocation of clinical privileges are identified in the following paragraphs, and apply to all practitioners included within the scope of this Handbook.

1. A physician or dentist who surrenders clinical privileges, resigns, retires, etc., during an investigation relating to possible professional incompetence or improper professional conduct or in return for not conducting such investigation must be reported to the NPDB in accordance with VA regulations 38 CFR Part 46 and VHA Handbook 1100.17. This includes the failure of a practitioner to request renewal of privileges while under investigation for professional incompetence or improper professional conduct.

2. Due process under these circumstances is limited to a hearing to determine whether the physician or dentist's surrender of clinical privileges, resignation, retirement, etc. occurred during such an investigation. If the practitioner does not request this limited hearing, the practitioner waives the right to further due process for the NPDB report and needs to be reported immediately.

(c) Adverse Professional Review Action. Any final professional review action that adversely affects the clinical privileges of a practitioner for a period longer than 30 days, including the surrender of clinical privileges or any voluntary restriction of such privileges, while the physician or dentist is under investigation, is reportable to the NPDB pursuant to the provisions of the VHA policy regarding NPDB reporting.

1. Summary Suspension. Clinical privileges may be summarily suspended when the failure to take such action may result in an imminent danger to the health of any individual. Summary suspension pending comprehensive review and due process, as outlined in subparagraphs 14i, on reduction and revocation, is not reportable to the NPDB. However, the notice of summary suspension to the physician or dentist needs to include a notice that if a final action is taken, based on professional competence or professional conduct grounds, both the summary suspension, if greater than 30 days, and the final action will be reported to the NPDB. The notice of summary suspension needs to contain a notice to the individual of all due process rights. **NOTE:** See Appendix E for Sample Advisement to Licensed Health Care Professional of Summary Suspension of Clinical Privileges.

a. When privileges are summarily suspended, the comprehensive review of the reason for summary suspension should be accomplished within 30 calendar days of the suspension with recommendations to proceed with formal procedures for reduction or revocation of clinical privileges forwarded to the facility Director for consideration and action. In those instances where the comprehensive review cannot be accomplished in 30 days, the circumstances should be documented with an expectation of when the comprehensive review will be completed. The facility Director must make a decision within 5 business days of receipt of the recommendations. This decision could be to exonerate the practitioner and return privileges to an active status or that there is sufficient evidence of improper professional conduct or incompetence to warrant proceeding with a reduction or revocation process.

**NOTE:** *Proceeding to the reduction or revocation process requires appropriate due process. Guidance needs to be sought from Regional Counsel and Human Resources to ensure due process is afforded. It is only after the due process is completed, a final action taken by the facility Director, and all appeals have been exhausted that the summary suspension and subsequent reduction or revocation of clinical privileges of a physician or dentist is reported to the NPDB.*

b. Administrative Denial of Privileges. If the practitioner's clinical privileges are pending renewal and due to expire during a summary suspension or due process procedures for reduction or revocation, the clinical privileges must be denied pending outcome of the review and due process procedures. This denial is considered administrative until such time as a final decision is made in the summary suspension or due process procedures. This final decision determines whether an adverse action has occurred and the responsibility for reporting of the action. If the final action results in what would have been a reportable event, it must be reported in accordance with VHA Handbook 1100.17.

2. **Automatic Suspension of Privileges.** Any time a practitioner is removed from patient care, and the reason does not result in a Summary Suspension of clinical privileges (see subpar. 14 l(3)(e)1) consideration should be given to automatically suspending privileges for administrative reasons. An example could include a practitioner who failed to maintain mandatory requirements for membership to the medical staff. The process for automatic suspension of privileges must be defined in the Medical Staff Bylaws.

a. Such instances must be weighed against the potential for substandard care, professional misconduct, or professional incompetence. A thorough review of the circumstances must be documented with a determination of whether the cause for the automatic suspension does or does not meet the test of substandard care, professional misconduct, or professional incompetence.

b. Under no circumstances should there be more than three automatic suspensions of privileges in 1 calendar year, and no more than 20 days per calendar year. If there are more than three automatic suspensions of privileges in 1 calendar year, or more than 20 days of automatic suspension in a calendar year, a thorough assessment of the need for the practitioner's services needs to be performed and documented and appropriate action taken. Any action is to be reviewed against all reporting requirements. **NOTE:** *There may be circumstances where an automatic suspension of clinical privileges is warranted but resolution cannot occur in 20 calendar days. Under these special circumstances documentation of the reason resolution*

*cannot occur in this time frame is required. Appropriate follow-up is required to close the Automatic Suspension once resolution is attained. Examples of such circumstance could include a practitioner who is accused of a crime unrelated to clinical practice or is being investigated for fraudulent use of a Government Credit Card, both of which could take well over 20 days to resolution.*

(d) Procedures Applicable to Administrative Heads. Procedures to reduce and revoke clinical privileges identified within this Handbook are applicable to Directors, COSs, CMOs, and VISN Directors. All responsibilities normally assumed by the COS during the clinical privileging reduction or revocation process must be assigned to an appropriate practitioner who serves as acting chair of the medical staff's Executive Committee. The COS may appeal the Director's decision, or the Director may appeal the Associate Director's decision, regarding the reduction of privileges decision to the VISN Director, just as all practitioners may appeal such a decision. A VISN Director whose clinical privileges to practice at a given facility are reduced or revoked may appeal to the Chief VISN Officer. **NOTE:** *See Appendix F for Sample Advisement to Licensed Health Care Professional of Automatic Suspension of Clinical Privileges.*

#### (4) **Reduction of Privileges, The Process**

(a) Recommendations to reduce a practitioner's privileges must be made by the Executive Committee of the Medical Staff, based upon review and deliberation of clinical performance and professional conduct information. Initially, the practitioner receives a written notice of the proposed changes in privileges from the COS. The notice must include a discussion of the reason(s) for the change and the process that will be afforded the practitioner to respond to this recommendation. The notice to a physician or dentist also needs to indicate that if a reduction is effected based on the outcome of the proceedings, and the reduction is for greater than 30 days, a report must be filed with the NPDB, with a copy to the appropriate SLBs in all states in which the practitioner holds a license, and in the State in which the facility is located. The notice must include a statement of the practitioner's right to be represented by an attorney or other representative of the practitioner's choice throughout the proceedings. The notice needs to advise that a physician or dentist who surrenders clinical privileges, resigns, retires, etc., during an investigation relating to possible professional incompetence or improper professional conduct must be reported to the NPDB in accordance with VA regulations 38 CFR Part 46 and VHA Handbook 1100.17. This includes the failure of a practitioner to request renewal of privileges while under investigation for professional incompetence or improper professional conduct or to avoid such investigation.

(b) The practitioner must be allowed to review all evidence not restricted by regulation or statute upon which proposed changes are based. Following that review, the practitioner may respond in writing to the COS's written notice of intent. The practitioner must submit a response within 10 business days of the COS's written notice and access to the available evidence. If requested by the practitioner, the COS may grant an extension for a brief period, normally not to exceed 10 additional business days, except in extraordinary circumstances.

**NOTE:** *Prior to releasing any information to the practitioner or any other individual associated with the review, consultation with the facility Privacy Officer or Regional Counsel is appropriate.*

(c) A complete package including the evidence, the recommendation of the Executive Committee of the Medical Staff, and any written statement submitted by the practitioner is forwarded to the facility Director. The facility Director must make, and document, a decision on the basis of the record. If the practitioner disagrees with the facility Director's decision, a hearing may be requested. The practitioner must submit the request for a hearing within 5 business days after receipt of decision.

(d) The facility Director must appoint a review panel of three professionals, within 5 business days after receipt of the practitioner's request for hearing. These three professionals will conduct a review and hearing. At least two members of the panel must be members of the same profession. If specialized knowledge is required, at least one member of the panel must be a member of the same specialty. This review panel hearing is the only hearing process conducted in connection with the reduction of privileges. Any other review processes must be conducted on the basis of the record. The hearing must proceed as follows:

1. The practitioner must be notified in writing of the date, time, and place of the hearing. The date of the hearing must not be less than 20 business days and not more than 30 business days from the date of notification letter.

2. During such hearing, the practitioner has the right to:

a. Be present throughout the evidentiary proceedings.

b. Be represented by an attorney or other representative of the practitioner's choice.

**NOTE:** *If the practitioner is represented, this individual is allowed to act on behalf of the practitioner including questioning and cross-examination of witnesses.*

c. Cross-examine witnesses.

**NOTE:** *The practitioner has the right to purchase a copy of the transcript or tape of the hearing.*

3. In cases involving reduction of privileges, a determination must be made as to whether disciplinary action should be initiated.

4. The panel must complete the review and submit the report within 15 business days from the date of the close of the hearing. Additional time may be allowed by the facility Director for extraordinary circumstances or cause.

(e) The panel's report, including findings and recommendations, must be forwarded to the facility Director, who has authority to accept, reject, accept in part, or modify the review panel's recommendations.

(f) The facility Director must issue a written decision within 10 business days of the date of receipt of the panel's report. If the practitioner's privileges are reduced, the written decision must indicate the reason(s). The signature of the facility Director constitutes a final action and, if the practitioner is a physician or dentist, the reduction is reportable to the NPDB.

(g) If the practitioner wishes to appeal the Director's decision, the practitioner may appeal to the appropriate VISN Director within 5 business days of receipt of the facility Director's decision. This appeal option will not delay the submission of the NPDB report. If the Director's decision is overturned on appeal, the report to the NPDB must be withdrawn.

(h) The VISN Director must provide a written decision, based on the record, within 20 business days after receipt of the practitioner's appeal. **NOTE:** *The decision of the VISN Director is not subject to further appeal.*

#### (5) **Revocation of Privileges, the Process**

(a) Recommendations to revoke a practitioner's privileges must be made by the Executive Committee of the Medical Staff, based upon review and deliberation of clinical performance and professional conduct information.

1. A revocation of privileges requires removal from both employment or contractual termination or expiration and appointment to the medical staff, unless there is a basis to reassign the practitioner to a position not requiring clinical privileges. Such an action may still result in reporting to the NPDB if the revocation and reassignment is for substandard care, professional incompetence, or professional misconduct. An example could be the revocation of a surgeon's privileges for clinical practice issues, when reassignment to a non-surgical area is beneficial to meeting other needs of the facility.

2. When revocation of privileges is proposed and combined with a proposed demotion or dismissal, the due process rights of the practitioner must be accommodated by the hearing provided under the dismissal process. Where removal is proposed for a permanent, full-time title 38 employee, the due process procedures for removal and revocation of privileges must be combined. Dismissal constitutes a revocation of privileges, whether or not there was a separate and distinct privileging action, and must be reported if the practitioner is a physician or dentist without further review or due process to the NPDB.

a. Revocation procedures must be conducted in a timely fashion. Appropriate action must be taken to see that the practitioner whose privileges are ultimately revoked does not remain in the same position for which the privileges were originally required (see App. G for Sample Advisement to Licensed Health Care Professional of Clinical Practice Review).

b. Due process under all applicable policies and procedures must be afforded the practitioner. Medical Staff Bylaws may not provide due process in addition to that established by VA. A coordination of all applicable due process procedures in advance will safeguard VA meeting obligations to the practitioner and the Agency in a timely manner. **NOTE:** *An advance review by and consultation with Regional Counsel is strongly recommended.*

3. When revocation of privileges is proposed and not combined with a proposed demotion or dismissal, the due process procedures under reduction of privileges must pertain.

(b) In instances where revocation of privileges is proposed for permanent employees appointed under 38 U.S.C. 7401(1), the revocation proceedings must be combined with proposed



action to discharge the employee under 38 U.S.C., Part V, Chapter 74, Subchapter V, or in accordance with current VA statutes, regulations, and policy. A due process proceeding for the revocation of privileges occurs through this process including the Disciplinary Appeals Board (DAB) process. There is no due process proceeding or appeal at the facility level.

(c) In those instances where the permanent employee was appointed under 38 U.S.C. 7401(3), the revocation proceedings must be combined with proposed action to discharge the employee under VA Handbook 5021, Part 1, Employee/Management Relations, or current VA statutes, regulations, and policy.

1. Employees appointed under 38 U.S.C. 7401(3) are entitled to appeal of adverse personnel actions to the Merit Protection Standards Board in accordance with VA Handbook 5021. Once completed, the due process proceeding for the revocation of privileges occurs. In those instances where the separation is sustained, due process proceedings are afforded the practitioner in accordance with subparagraph 14I(5)(g).

2. Physicians and dentists whose privileges are revoked for substandard care, professional incompetence, or professional misconduct, must be reported to the NPDB in accordance with the VHA policy on NPDB reporting. In addition, the practitioner's practice must be reviewed for reporting to SLB(s) consistent with VHA policy on SLB reporting.

(d) For probationary employees appointed under 38 U.S.C. 7401(1), the proposed revocation requires probationary separation procedures contained in VA Handbook 5021. Where proposed revocation is based on substandard care, professional misconduct, or professional incompetence, the probationary employee must be provided with the due process procedures that are provided for revocation of privileges, in addition to the procedures contained in VA Handbook 5021 for separation (i.e., the probationary procedures do not afford sufficient due process). If the separation is sustained, the employee's privileges are automatically revoked. The employee is entitled only to the due process procedures that are outlined in subparagraph 14I(5)(g) to determine if the revocation is based on substandard care, professional misconduct, or professional incompetence. Upon conclusion of the due process procedures the reason for the revocation is sustained as substandard care, professional misconduct, or professional incompetence, reporting to the NPDB in accordance with VHA policy is required. **NOTE:** *VA reports only final actions sustained for physicians and dentists to the NPDB, but due process procedures are required for all privileged practitioners for whom revocation occurs.*

(e) For employees appointed under 38 U.S.C. 7405, the proposed revocation requires actions to separate the employee under the provisions of VA Handbook 5021. Where proposed revocation is based on substandard care, professional misconduct, or professional incompetence, the temporary employee must be provided with the due process procedures that are provided for revocation of privileges (see subpar. 14I(5)(g)). This right to due process is only to determine if the revocation is based on substandard care, professional misconduct, or professional incompetence. When the proposed revocation is based on other grounds, the proposed revocation must be combined with the applicable separation procedures contained in VA Handbook 5021. Physicians and dentists whose privileges are revoked based on substandard care, professional incompetence, or professional misconduct must be reported to the NPDB according to procedures identified in the VHA policy regarding NPDB reporting.



(f) Independent contractors and/or subcontractors acting on behalf of VA are subject to the provisions of VA policies on credentialing and privileging and NPDB reporting. In the following circumstances, VA must provide the contractor and/or subcontractor with appropriate internal VA Medical Center due process, pursuant to the provisions of this Handbook regarding reduction and revocation of privileges, prior to reporting the physician or dentist contractor and/or subcontractor to the NPDB, and filing a copy of the report with the SLB(s) in the state(s) in which the contractor and/or subcontractor is licensed and in which the facility is located:

1. Where VA terminates a contract or requires removal of an individual practitioner of the contractor for possible incompetence or improper professional conduct, thereby automatically revoking the medical staff appointment and associated clinical privileges of the contractor or an individual practitioner of the contractor, the contract practitioner(s) is/are entitled only to due process procedures to determine if revocation is based on substandard care, professional misconduct, or professional incompetence.

2. Where VA requires that the contractor remove and replace a subcontractor under a continuing contract for possible incompetence or improper professional conduct, the subcontractor's practitioner(s) privileges is/are automatically revoked. The subcontractor practitioner(s) is/are entitled only to due process procedures to determine if revocation is based on substandard care, professional misconduct, or professional incompetence.

3. Where the physician or dentist contractor and/or subcontractor voluntarily surrender(s) a medical staff appointment and associated privileges, either while under investigation relating to possible incompetence or improper professional conduct or to avoid such investigation, the surrender of clinical privileges while under investigation or to avoid investigation must be reported to the NPDB without delay.

4. Where a contract naturally expires, both the medical staff appointment and associated clinical privileges of the contractor's and/or subcontractor's personnel are automatically terminated. This is not reportable to the NPDB.

5. Clinical privileges are granted for a period not to exceed two years. Where a contract is renewed or the period of performance extended beyond the period granted by the initial credentialing process, the contractor and/or subcontractor's medical practitioner(s) must be credentialed and privileged similar to the initial credentialing process, with the exception that non-time limited information, e.g., education and training, does not need to be re-verified.

(g) Fair Hearing for Proposed or Effected Revocation of Privileges for other than Permanent Employees. When a revocation of privileges is proposed in conjunction with a proposed removal, or subsequent to the separation depending on the appointment authority, the practitioner must be served notice of the revocation and appropriate due process procedures. The notice must include a discussion of the reason(s) for the revocation. When the practitioner is a physician or dentist, the notice also needs to indicate that if a revocation is effected or sustained based on the outcome of the proceedings, and the revocation is for greater than 30 days, a report must be filed with the NPDB, with a copy to the appropriate SLBs in all states in which the physician or dentist holds a license, and in the State in which the facility is located. The notice must include a statement of the practitioner's right to be represented by an attorney or other representative of the

practitioner's choice throughout the proceedings. The notice should also advise that a physician or dentist who surrenders clinical privileges, resigns, retires, etc., during an investigation relating to possible professional incompetence or improper professional conduct or to avoid such investigation, must be reported to the NPDB in accordance with VA regulations 38 CFR Part 46 and VHA Handbook 1100.17. This includes the failure of a practitioner to request renewal of privileges while under investigation for professional incompetence or improper professional conduct.

**NOTE:** *Fair hearing and due process proceedings can and should occur even if the practitioner has been separated. A final action does not occur until after all due process proceedings have been completed unless otherwise noted.*

1. The practitioner must be allowed to review all evidence not restricted by regulation or statute upon which proposed changes to privileges are based. Following that review, the practitioner may respond in writing to the COS's written notice of intent. The practitioner must submit a response within 10 business days of the COS's written notice and access to the evidence. If requested by the practitioner, the COS may grant an extension for a brief period, normally not to exceed 10 additional business days, except in extraordinary circumstances.

**NOTE:** *Prior to releasing any information to the practitioner or any other individual associated with the review, consultation with the facility Privacy Officer or Regional Counsel is appropriate.*

2. A complete package including the evidence, the recommendation of the Executive Committee, and any written statement submitted by the practitioner is forwarded to the facility Director. The facility Director must make, and document, a decision on the basis of the record. If the practitioner disagrees with the facility Director's decision, a hearing may be requested. The practitioner must submit the request for a hearing within 5 business days after receipt of decision.

3. The facility Director must appoint a review panel of three professionals, within 5 business days after receipt of the practitioner's request for hearing. These three professionals will conduct a review and a hearing. At least two members of the panel must be members of the same profession. If specialized knowledge is required, at least one member of the panel must be a member of the same specialty. This review panel hearing is the only hearing process conducted in connection with the revocation of privileges. Any other review processes must be conducted on the basis of the record. The hearing will proceed as follows:

a. The practitioner must be notified in writing of the date, time, and place of the hearing. The date of the hearing must not be less than 20 business days and not more than 30 business days from the date of notification letter.

b. During such hearing, the practitioner has the right to:

(1) Be present throughout the evidentiary proceedings.

- (2) Be represented by an attorney or other representative of the practitioner's choice.

**NOTE:** *If the practitioner is represented, this individual is allowed to act on behalf of the practitioner including questioning and cross-examination of witnesses.*

- (3) Cross-examine witnesses.

**NOTE:** *The practitioner has the right to purchase a copy of the transcript or tape of the hearing.*

c. The panel must complete the review and submit the report within 15 business days from the date of the close of the hearing. Additional time may be allowed by the facility Director for extraordinary circumstances or cause.

d. The panel's report, including findings and recommendations, must be forwarded to the facility Director, who has authority to accept, reject, accept in part, or modify the review panel's recommendations. **NOTE:** *If the facility Director accepts in part or modifies the review panel's recommendations which results in a reduction of the practitioner's clinical privileges, reporting to the NPDB must be initiated in accordance with VHA policy on NPDB reporting.*

e. The facility Director must issue a written decision within 10 business days of the date of receipt of the panel's report. If the revocation of practitioner's privileges is sustained, the written decision must indicate the reason(s). The signature of the facility Director constitutes a final action and the reduction is reportable to the NPDB only for physicians or dentists.

f. If the practitioner wishes to appeal the Director's decision, the practitioner may appeal to the appropriate VISN Director within 5 business days of receipt of the facility Director's decision. This appeal option will not delay the submission of the NPDB report. If the Director's decision is overturned on appeal, the report to the NPDB must be withdrawn.

g. The VISN Director must provide a written decision, based on the record, within 20 business days after receipt of the practitioner's appeal. The decision of the VISN Director is not subject to further appeal.

(6) **Management Authority.** Nothing in these procedures restricts the authority of management to temporarily detail or reassign a practitioner to non-patient care areas or activities, thus in effect suspending privileges while the proposed reduction of privileges or discharge, separation, or termination is pending.

(a) The facility Director, acting in the position of Governing Body as defined in the Medical Staff Bylaws, is the final authority for all privileging decisions. This decision must be based on the recommendations of the appropriate Service Chief(s), COS, and/or Executive Committee of the Medical Staff.

(b) Furthermore, the facility Director, on the recommendation of the COS, may summarily suspend privileges, on a temporary basis, when there is sufficient concern regarding patient safety or specific practice patterns.

(c) Nothing precludes VA from terminating a practitioner in accordance with VA Handbook 5021 procedures when the separation is not for a professional reason. Health care professionals appointed under authority of 38 U.S.C. 7405 may be terminated in accordance with VA Directive and Handbook 5021, when this is determined to be in the best interests of VA.

m. **Inactivation of Privileges.** The inactivation of privileges occurs when a practitioner is not an active member of the medical staff. It is difficult to quantify “extended period of time,” but facilities need to consider inactivation of privileges for extended periods of no clinical practice or continued medical knowledge skills and learning, or when there is no formal clinical relationship between the facility and the practitioner.

(1) Conditions that would be considered reasons for inactivation of privileges may include extended sick leave and sabbatical with or without clinical practice while on sabbatical. When practitioners return to the medical center following these circumstances, credentialing and privileging activities are similar to the initial credentialing process with the exception that non-time limited information, e.g., education and training, does not need to be re-verified. Inactivation of privileges may not be used as a substitute for termination of medical staff appointment and/or revocation of privileges where such action(s) is warranted.

(2) At the time of inactivation of privileges, including separation from the medical staff, the facility Director ensures that within 7 calendar days of the date of separation, information is received suggesting that practitioner met generally accepted standards of clinical practice and there is no reasonable concern for the safety of patients in accordance with VHA Handbook 1100.18.

n. **Deployment and/or Activation Privilege Status.** In those instances where a practitioner is called to active duty, the practitioner's privileges are to be placed in a Deployment and/or Activation Status. The credential files continue to remain active with the privileges in this new status. If at all possible, this process for returning privileges to an active status must be communicated to practitioners before deployment.

(1) Practitioners returning from active duty must be asked to communicate with the medical center staff as soon as possible upon returning to the area. ***NOTE: This will hopefully occur with as much lead-time as possible.***

(2) The practitioner must update the electronic Credentials File after the file has been reopened for credentialing updating licensure information, health status, and professional activities while on active duty.

(3) The credentials file must be brought to a verified status. If the practitioner performed clinical work while on active duty, an attempt must be made to confirm the type of duties, the practitioner's physical and mental ability to perform these duties, and the quality of the work; this information must be documented.

(4) The verified credentials, the practitioner's request for returning the privileges to an active status, and the Service Chief's recommendation are to be presented to the Executive Committee of the Medical Staff for review and recommendation. The decision of the Executive Committee

of the Medical Staff must be documented (the minutes must reflect the documents reviewed and the rationale for the stated conclusion) and forwarded to the Director for recommendation and approval of restoring the practitioner's privileges to Current and Active Status from Deployment and/or Activation Status.

(5) In those instances when the practitioner's privileges did not expire during deployment, the expiration date of the original clinical privileges at the time of deployment continues to be the date of expiration of the restored clinical privileges.

(6) In those instances where the privileges lapsed during the call to active duty, the practitioner needs to provide additional references for verification and the medical center staff needs to perform all verifications required for reappointment.

(7) In those instances where the practitioner was not providing clinical care while on active duty, the practitioner in cooperation with the Service Chief and/or the Executive Committee of the Medical Staff must consider the privileges held prior to the call to active duty and whether a request for modification of these privileges needs to be initiated, on a short-term basis.

(8) If the file cannot be brought to a verified status and the practitioner's privileges restored by the Director, the practitioner can be granted a Temporary Appointment to the Medical Staff not to exceed 60 calendar days during which time the credentialing and privileging process must be completed. In order to qualify for this temporary appointment, when returning from active duty the following must be documented in VetPro:

(a) Verification of all licenses that were current at the time of deployment and/or activation as current and unrestricted with no previous or pending adverse actions on the Temporary Enrollment Screen.

(b) Active registration with the NPDB-HIPDB CQ.

(c) A current response from the FSMB.

(d) Marking of the Temporary Enrollment Screen as reinstatement from Deployment and/or Activation.

(e) Documentation of the Temporary Appointment on the Appointment Screen not to exceed 60 calendar days.

**NOTE:** *No step in this process should be a barrier in preventing the practitioner from returning to the medical center in accordance with Uniformed Services Employment and Reemployment Rights Act of 1994.*

## **15. DOCUMENTATION OF THE MEDICAL STAFF APPOINTMENT AND CLINICAL PRIVILEGES**

a. Upon completion of the verification of credentials, recommendations by the appropriate Service Chief and committee(s), and approval by the Director (acting as the Governing Body),

the documentation of the appointment and granting of clinical privileges can be completed. Medical staff appointments and the granting of clinical privileges are to be entered in VetPro and the period may not exceed 2 years. There is no provision for any extension of appointments or privileges.

b. The appointment can be effective as of the date signed by the Director, but may not become effective at a date later than 30 calendar days from the date signed by the Director or 45 calendar days after the recommendation of the Executive Committee of the Medical Staff, whichever is shorter.

**NOTE:** *The timeframes for when the appointment can become effective must comply with all other timeframes established in this Handbook (see subpar. 13c(4)).*

c. The type of employment appointment, i.e., full-time, part-time, WOC, consultant, contract, fee basis, sharing agreement, or other needs be specified, the dates of the appointment, Service and/or Product Line, the Medical Center Director, the signature location of the approval document, and any other appropriate comments are to be entered on the appropriate screens in VetPro including: Service Chief's Approval, Committee Minutes, and Appointment Screens.

d. When indicated, appropriate documentation is to be entered into the Appointment screen of VetPro for less than full appointment, including Temporary and Expedited Appointments.

e. At the time of initial evaluation, if it is determined that no medical staff appointment or clinical privileges will be granted, this action is to be documented in the appropriate supporting documentation at the VA facility, i.e., committee minutes and a "Do Not Appoint" screen must be entered with appropriate comments. The electronic file then needs to be inactivated transferring the file to VetPro VA Central Office.

**f. Concurrent Appointments and Sharing of Files**

(1) In those instances where a practitioner is providing care at more than one facility, including telemedicine services, medical staff appointments at all facilities need to be coordinated and concurrent.

(2) When the file is reopened for credentialing, each facility at which the practitioner holds a medical staff appointment needs to start the re-privileging process.

(3) Instructions to the practitioner need to clearly state that:

(a) The re-privileging process is going to be done concurrently at all facilities,

(b) The practitioner only needs to submit the renewal application in VetPro once, and

(c) The practitioner must attest to each facility's Bylaws on the "Sign/Submit" screen.

(4) Each facility needs to consider sharing the practitioner's responses to the Supplemental Attestation Questions and the references submitted as part of this coordinated credentials



process. In coordinating this effort, the credentialers need to determine who is going to request documentation of any items identified on the Supplemental Attestation Questions, the references, and/or peer appraisals.

(5) A facility may not use any time-limited verifications that are obtained prior to the practitioner attesting to the facility's Medical Staff Bylaws. Non-time limited information, such as education or training verification, may be used.

(6) Each facility needs to obtain the license verifications and document registration in the NPDB-HIPDB CQ.

(7) If at any point during the time a practitioner is shared, any of the facilities suspend the practitioner's privileges, or takes an action that is considered to be an adverse personnel medical staff appointment, or privileging action, the facility taking the action must notify all facilities that share the practitioner of the action. This notification needs to be made to the COS of each facility for appropriate review and action within the privileges granted at the shared facility.

g. **Conversion of Appointment Type with No Change in Privileges**

(1) In those instances where a provider has held a specific type of relationship and is being converted to a different type of relationship (i.e., part-time to appointment to contract, contract to Human Resource fee basis, etc.), the practitioner must apply for privileges. **NOTE:** *A practitioner who is converting from part-time to full-time appointment or Human Resource non-VA care to part-time appointment is continuing in the same type of employment relationship under a different type of Human Resource appointment. These practitioners do not need to apply for privileges for this appointment because there is no change in the relationship with the facility.*

(2) Prior to conversion to a different type of appointment relationship, all time-limited information must be verified, regardless of the period of time since previous verification.

(3) The NPDB-HIPDB CQ registration must be confirmed.

(4) The information obtained in this process must be evaluated and reviewed by the appropriate individuals in the same manner as initial appointments or reappraisal. This review must be documented in the appropriate minutes, as well as the credentialing and privileging folder and VetPro. The appointment date remains the same as the previous appointment with the expiration date not to exceed 2 years from that date.

## 16. REFERENCES

- a. Title 38 U.S.C. 7304, 7401, 7402, 7405, 7409, and 7461 through 7464.
- b. Title 45 CFR Part 60.
- c. Public Laws (Pub. L.) 99-166, sec. 206, and 99-660, sec. 422 and its revisions.

- d. Pub. L. 100-177, Sec. 402.
- e. Pub. L. 106-117, sec. 209.
- f. Pub. L 105-33, sec. 4331(c).
- g. Pub. L 104-191, sec. 221.
- h. Title 38 CFR Part 46.
- i. Title 5 CFR Parts 315, 731, and 752.
- j. VA Handbook 5005.
- k. VA Handbook 5007.
- l. VA Directive and Handbook 5021.
- m. VA Handbook 6502.1
- n. The Joint Commission, Comprehensive Accreditation Manual for Hospitals.
- o. Privacy Act System of Records Notice for Healthcare Provider Records (77VA10Q).

**STANDARD CREDENTIALING AND PRIVILEGING FOLDER****1. General Provisions**

a. The Credentialing and Privileging folder is the standard system for the establishment and maintenance of credentialing and privileging and related documents, regardless of the employment appointment (e.g., full-time, part-time, without compensation, consultant, contract, fee basis, sharing agreement, or other). Other information related to employment appointment is located in the employee's Official Personnel Folder, or for Title 38 employees who have personnel folders, in the Merged Records Personnel Folder (MRPF). The contents of the folder are based on requirements outlined in the Veterans Health Administration (VHA) Handbook 1100.19, Credentialing and Privileging.

b. The facility Chief of Staff is responsible for maintenance of the Credentialing and Privileging system. The folder must be kept active as long as the practitioner is employed by the Department of Veterans Affairs (VA) facility. If the practitioner transfers to another VA facility, the folder must transfer to the new location.

**2. Format and/or Filing Sequence**

a. The model folder provided to all facilities on April 9, 1991, represents a practitioner who has held appointment or has been utilized to provide on-station patient care for more than 2 years. An appropriate Credentialing and Privileging folder is to be established for each practitioner regardless of the length of service. The specific sections of the standard folder are identified as:

(1) **Section I.** Application, Reappraisal, and local Medical Facility Information.

(2) **Section II.** Clinical Privileges.

b. Sections I and II provide a complete overview of the individual practitioner's qualifications, the type of appointment, and the clinical privileges.

**OCCUPATIONS COVERED BY TITLE 38 UNITED STATES CODE (U.S.C.)  
SECTION 7402(f), REQUIREMENTS**

1. The following list of occupations and job series indicates whether a State license (L), certification (C), or registration (R) is required by the statute, regulation, or Veterans Health Administration (VHA) qualification standard.
2. For those individuals hired on or after November 30, 1999, the date to be used to determine the individual's eligibility is the date the credential requirement was implemented. For example, the Department of Veterans Affairs (VA) first required the credential in 1972, the individual lost the credential in 1983, and the individual applies, or was appointed, to VA after November 30, 1999, the individual is not eligible for VA employment in the covered position, unless the lost or surrendered credential is restored to a full and unrestricted status. However, if the individual lost the credential in 1970, before it was a VA requirement, eligibility for VA employment would not be affected.

<b>Occupation</b>	<b>Series</b>	<b>L, C, Date 1st Required</b>
Chiropractor*	none	6/16/2004
Expanded Function Dental Auxiliary (EFDA)	682	7/1/1982
Psychologist*	180	8/10/1982
Social Worker	185	6/25/1992
Physician	602	1/3/1946
Nurse	610	1/3/1946
Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN)	620	2/8/1972
Physical Therapist	633	10/29/1982
Pharmacist	660	1/3/1946
Optometrist*	662	8/14/1952
Podiatrist*	668	11/8/1966
Dentist	680	1/3/1946

\* May be practicing as an licensed independent practitioner, but is still subject to Title 38 United States Code (U.S.C.) 7402(f).

3. There are a number of professions identified in paragraph 2 of this Appendix for whom there are proposed changes to the VHA Qualification Standards. If a requirement for state issued L, C, or R is added as a new requirement, the conditions of 38 U. S. C. 7402(f) are effective as of the date the credential is required.

## GUIDANCE ON WHEN TO QUERY THE FEDERATION OF STATE MEDICAL BOARDS

1. **Initial Appointment.** The applicant for an initial medical staff appointment must be screened against the Federation of State Medical Boards (FSMB) disciplinary files by direct computer access using VetPro in accordance with the following procedures (see diagram in App. D for guidance in the decision making process). The only exception to this is for those practitioners being appointed in accordance with Temporary Medical Staff Appointments for Urgent Patient Care Needs.

a. The physician must submit a complete VetPro application.

b. To allow for the greatest matching ability in the query of the FSMB disciplinary file, the *Education* screen must be in a verified status either through verification of education or, for International medical graduates, the Educational Commission for Foreign Medical Graduates (ECFMG) screen must be in a verified status prior to the submission of the query. VetPro does not allow for a query to be submitted if one of these two screens is not in a verified status.

c. The facility designee, e.g., the credentialing staff, must submit the electronic query through the VetPro FSMB Query screen of the practitioner's record.

d. VetPro electronically receives the response from the FSMB and appends it to the *License* screen. If there is no match on the query, this is displayed on the VetPro *License* screen similar to the no match response received from the National Practitioner Data Bank (NPDB) – Health Integrity and Protection Data Bank (HIPDB) stating “*No Match.*” The response to the FSMB query is a Portable Document Format (PDF) file and retrievable through the VetPro *License* screen and it can be viewed when VetPro launches Adobe Acrobat Reader for viewing and printing.

2. **Reappointment.** Those practitioners who held Department of Veterans Affairs (VA) medical treatment facility medical staff appointments and were enrolled in VetPro prior to April 26, 2002, have been submitted to the FSMB for screening against the FSMB Disciplinary Files by VA Central Office during the national review of appointed practitioners in May 2002, if the necessary information was available in VetPro. Confirmation of this query or identification of the need to query must be in accordance with the following procedures (see App. D).

a. For those practitioners for whom there was a *Match* with the FSMB Disciplinary Files, reports were forwarded to the appropriate facility for scanning in to the *Licensure* screen. For those practitioners who had not submitted credentialing information through VetPro when the report was returned to the facility, the report may have been scanned in to the *Personal Profile* screen.

b. Where the VA Central Office screening produced *No Match*, VA facilities are being provided the information for documenting that a query was made, the date of the query, and the query batch number. Facilities were directed to document this information on a Report of Contact on the VetPro *License* screen.

c. If, through this process, there is no documented query of the FSMB:

(1) The *Education* screen must be in a verified status either through verification of education or for International medical graduates, the *ECFMG* screen must be in a verified status prior to the submission of the query. **NOTE:** *VetPro does not allow for a query to be submitted if one of these two screens is not in a verified status.*

(2) The facility designee, e.g., the credentialing staff, must submit the electronic query through the VetPro FSMB Query screen of the practitioner's record.

(3) VetPro receives the response from the FSMB and appends it to the *License* screen. If there is no match on the query, this is displayed on the VetPro *License* screen similar to the no match response received from the NPDB-HIPDB stating "*No Match.*" The response to the FSMB query is a PDF file retrievable through the VetPro *License* screen and it can be viewed when VetPro launches Adobe Acrobat Reader for viewing and printing.

**3. Temporary Medical Staff Appointment for Urgent Patient Care Needs.** In those instances where there is a documented urgent patient care need requiring a temporary medical staff appointment, a query to the FSMB must be performed in accordance with the following procedures.

a. The VetPro *Temporary Enrollment* Screen must be completed by the VA medical facility staff.

b. The facility designee, e.g., the credentialing staff, must submit the electronic query through the VetPro FSMB Query screen of the practitioner's record.

c. VetPro receives the response from the FSMB and appends it to the *License* screen. If there is no match on the query, this is displayed on the VetPro *License* screen similar to the no match response received from the NPDB-HIPDB stating "*No Match.*" The response to the FSMB query is a PDF file retrievable through the VetPro *License* screen and it can be viewed when VetPro launches Adobe Acrobat Reader for viewing and printing.

**4. On-station Contract Practitioners.** On-station contract practitioners must be screened against the FSMB Disciplinary Files through VetPro for each appointment to each VA facility. This screening must be documented each time on the *Licensure* screen (see App. D). The only exceptions to this requirement are:

a. There has been no clinical practice between VA facility assignments, and

b. The time between VA facility assignments is less than 30 calendar days

**5. Break in Service.** If a practitioner has a break in service greater than 30 days or has practiced medicine during any break in service regardless of the length of time, a new screening against the FSMB Disciplinary Files is required. Files that have been previously archived through inactivation in the VetPro system and are re-activated for medical staff appointment at a



VA facility require a new screening against the FSMB Disciplinary Files. In both instances, this screening against the FSMB Disciplinary Files must be in accordance with this Handbook.

a. Those practitioners who have been screened against the FSMB Disciplinary Files by VA Central Office, or will be screened through VetPro, must be placed in VHA's FSMB Disciplinary Alerts Service. Those practitioners entered into the VHA's FSMB Disciplinary Alerts Service are continuously monitored. Any orders reported to the FSMB from licensing entities, as well as the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) and the Department of Defense (DOD), initiate an electronic alert that an action has been reported to the Veterans Health Administration (VHA)'s Credentialing and Privileging Program Director.

(1) The registration of practitioners into this system is based on these queries and only on these queries.

(2) This monitoring is on-going for registered practitioners.

(3) Alerts received by VHA's Credentialing and Privileging Program Director must be forwarded to the appropriate VA facility for primary source verification and appropriate action. The disciplinary information that pertains to the practitioner can then be downloaded and forwarded to the appropriate facility for review and inclusion in the practitioner's credentials file.

(4) Practitioner names must be removed from the VHA FSMB Disciplinary Alerts Service when:

(a) The practitioner file is inactivated in VetPro.

(b) The practitioner medical staff appointment lapses in VetPro.

(c) In either of these instances, a notation must be made in the VetPro file on the VetPro *Appointment* screen of removal from the VHA FSMB Disciplinary Alerts Service. Such a notation requires a new query to the FSMB Disciplinary Files; if the practitioner is appointed in VHA at a future time the practitioner's name must be placed back into the monitoring process.

b. The FSMB must invoice each VA facility for the queries made on a monthly basis.

**DECISION PROCESS FOR QUERIES OF THE FEDERATION OF  
STATE MEDICAL BOARD**



Decision Process for  
Queries of the Federat

**SAMPLE ADVISEMENT TO LICENSED HEALTH CARE PROFESSIONAL OF  
SUMMARY SUSPENSION OF PRIVILEGES**

Date

John Doe, M.D.  
1234 East Main  
Little Town, Big State 12345

Dear Dr. Doe:

This is to notify you that your privileges are summarily suspended effective \_\_\_\_ (this date) \_\_\_\_.  
This action is being taken upon the recommendation of the Chief of Staff since concerns have  
been raised to suggest that aspects of your clinical practice do not meet the accepted standards of  
practice and potentially constitute an imminent threat to patient welfare. \_\_\_\_ (Insert general  
statement on reason for summary suspension) \_\_\_\_ This suspension is in effect pending a  
comprehensive review of these allegations.

You have the opportunity to provide any information you desire to provide regarding these  
concerns. Correspondence needs to be sent within 14 calendar days from your receipt of this  
notice, and be addressed to:

Appropriate Contact  
Department of Veterans Affairs  
123 Street  
Anytown, USA 12345

The comprehensive review of the reasons(s) for the summary suspension must be accomplished  
within 30 calendar days of the suspension, with recommendations to proceed with formal  
procedures for reduction or revocation of clinical privileges forwarded to me for consideration  
and action. Within 5 working days of receipt of the recommendations, I will make a decision  
either to restore your privileges to an active status or that the evidence warrants proceeding with  
a reduction or revocation process. Since you cannot perform clinical duties during the review,  
you are removed from patient care and placed \_\_\_\_ (in an administrative position or on  
administrative leave, as applicable) \_\_\_\_.

Should the comprehensive review result in a tentative decision by me to restrict or revoke your  
privileges, and if appropriate, to take an adverse personnel action, you will be notified at that  
time of your rights as per VHA Handbook 1100.19 and VA Directive and Handbook 5021. You  
have a right to be represented by an attorney or other representative of your choice throughout  
the proceedings.

Summary suspension pending comprehensive review and due process is not reportable to the  
National Practitioner Data Bank (NPDB). However, if a final action against your clinical  
privileges is taken for professional incompetence or improper professional conduct, both the

## APPENDIX E

summary suspension and the final action, if greater than 30 days, will be reported to the NPDB, and a copy of the report must be sent to the State licensing boards in all states in which you hold a license and in \_\_\_\_ (Insert State in which facility is located) \_\_\_\_\_. **NOTE:** *Delete this paragraph if practitioner is not a physician or dentist.*

If you surrender or voluntarily accept a restriction of your clinical privileges, including by resignation or retirement, while your professional competence or professional conduct is under investigation during these proceedings or to avoid investigation, VA is required to file a report to the NPDB, with a copy to the appropriate State licensing board(s), pursuant to VA regulations in title 38 Code of Federal Regulations (CFR) Part 46 and VHA Handbook 1100.17, National Practitioner Data Bank Reports. **NOTE:** *Delete this paragraph if practitioner is not a physician or dentist.*

It is the policy of VA to report to State Licensing Boards those licensed health care professionals, whether currently employed or separated (voluntarily or otherwise), whose clinical practice during VA employment so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients (see 38 CFR Part 47). In the event you are found to not meet standards of care, consideration will be given whether, under these criteria, you should be reported to the appropriate State Licensing Board(s) pursuant to the provisions of VHA Handbook 1100.18, Reporting and Responding to State Licensing Boards.

If you have any questions, please contact \_\_\_\_ (Insert contact information) \_\_\_\_.

Sincerely yours,

Medical Center Director

**SAMPLE ADVISEMENT TO LICENSED HEALTH CARE PROFESSIONAL OF  
AUTOMATIC SUSPENSION OF CLINICAL PRIVILEGES**

Date

John Doe, M.D.  
1234 East Main  
Little Town, Big State 12345

Dear Dr. Doe:

This serves as notification that effective \_\_\_\_ (Insert date) \_\_\_\_, your clinical privileges have been administratively suspended based on the recommendation of the Professional Standards Board or Medical Executive Committee (MEC) due to \_\_\_\_ (Insert justification, such as delinquent dictations, expired license) \_\_\_\_. Corrective action should be accomplished within \_\_\_\_ (Insert #) \_\_\_\_ days of receipt of this notice. Once the \_\_\_\_ (Insert issue) \_\_\_\_ has been corrected, the Executive Committee of the Medical Staff will review your credentialing information and make a recommendation regarding reinstatement of your privileges. Until that time, you are removed from patient care and placed in an administrative position or on administrative leave. This action is being taken in accordance with the \_\_\_\_ (Insert Facility name) \_\_\_\_ Medical Staff Bylaws. The circumstances will be thoroughly reviewed to determine if the reason for this administrative suspension meets the criteria for substandard care, professional misconduct, or professional incompetence. This will then be reviewed against all reporting requirements.

Please note that a practitioner may not have more than three automatic suspensions in 1 calendar year, and no more than 20 days per calendar year. If either of these occurs, a review of the need for the practitioner's continued services will be performed.

Please sign and date the acknowledgment on the next page return it to the Office of the Chief of Staff by close of business today.

Should you have any questions or wish to discuss this issue, please feel free to contact the Chief of Staff.

Sincerely yours,

Medical Center Director

cc: Service or Product Line Chief

Page 2

**VA Form 10-0492, Advisement of Automatic Suspension of Clinical Privileges**



10-0492-fill  
Advisement of Autorr



**SAMPLE ADVISEMENT TO LICENSED HEALTH CARE PROFESSIONALS OF  
CLINICAL PRACTICE REVIEW**

Date

John Doe, MD  
1234 East Main  
Little Town, Big State 12345

Dear Dr. Doe:

This is to notify you that a review is being conducted of your clinical privileges. Concerns have been raised regarding your professional conduct or competence that suggest such conduct affects or could affect adversely the health or welfare of a patient, or patients. \_\_\_\_ (Insert general statement on reason for review) \_\_\_\_.

In accordance with VHA Handbook 1100.19, Credentialing and Privileging, and the \_\_\_\_ (Insert Facility Name) \_\_\_\_ Veterans Health Care System Medical Staff Bylaws, Fair Hearing and Appellate Review, you will be extended “due process” rights.

A review will be initiated to determine if your privileges could be adversely affected. You will be allowed to review all evidence not restricted by regulation or statute, collected by the review process upon which any proposed adverse action is based. Following that review, you may respond in writing to my written notice of intent. You must submit a response within 10 working days of receipt of written notice. If you request, I may grant an extension for a brief period, normally not to exceed 10 business days, except in extraordinary circumstances.

All information collected during the review will be forwarded to the facility Director for decision. The facility Director will make, and document, a decision on the basis of the record. Full and impartial consideration will be given to your reply if a reply is submitted. If you disagree with the facility Director’s decision, you may request a hearing. You must submit the request for a hearing within 5 business days after receipt of the decision.

If you request a hearing, the facility Director will appoint a review panel of three professionals, within 5 business days after receipt of your request for hearing, to conduct a review and hearing. At least two members of the panel will be members of your same profession. If specialized knowledge is required, at least one member of the panel must be a member of your specialty. This review panel hearing will be the only hearing process conducted in connection with the adverse privileging action; any other review processes will be conducted on the basis of the record. You will be advised in writing of the date, time, and place of the hearing.

During such hearing, you have the right to be present throughout the evidentiary proceedings, represented by an attorney or other representative of your choice, and to question and cross-examine witnesses. You have the right to purchase a copy of the transcript of the tape of the hearing.

The panel must complete the review and submit the report within 15 business days from the date of the close of the hearing. The facility Director may allow additional time for extraordinary circumstances or cause. The panel's report, including findings and recommendations regarding privileges, and whether disciplinary action should be initiated, will be forwarded to the facility Director, who has the authority to accept, reject, accept in part, or modify the review panel's recommendation.

The facility Director will issue a written decision within 10 business days of the date of the receipt of the panel's report. If your privileges are reduced, the written decision will indicate the reason(s). The facility Director's signature constitutes a final action, and if the reduction is for a period longer than 30 days on grounds related to professional incompetence or improper professional conduct, the reduction is reportable to the National Practitioner Data Bank (NPDB), with a copy to be sent to the appropriate State Licensing Boards in all states in which you hold a license(s) and in the State of \_\_\_\_ (Insert State in which facility resides) \_\_\_\_\_. This adverse action report to NPDB will be filed within 15 calendar days after the privileging action is made final by the facility Director. Prior to approving the report, the facility Director will notify you and provide you with an opportunity for discussion. The NPDB will send a copy of the computerized report to you with a limited comment period. You are not able to submit changes to the report; however, if you wish to appeal the decision, you may appeal to the Veterans Integrated Service Network (VISN) \_\_\_\_ (Insert VISN #) \_\_\_\_ Director within 5 business days of receipt of the facility Director's decision. This appeal option will not delay the submission of the NPDB report. If the facility Director's decision is overturned by the \_\_\_\_ (Insert VISN #) \_\_\_\_ Director, the report to the NPDB will be withdrawn.

The \_\_\_\_ (Insert VISN #) \_\_\_\_ Director will provide a written decision, based on the record, within 20 business days after receipt of your appeal. The decision of the VISN Director is not subject to further appeal.

Should you surrender or voluntarily accept a restriction of your clinical privileges, or resign or retire from your medical staff position with the Department of Veterans Affairs (VA) while your professional competence or professional conduct is under investigation during these proceedings or to avoid investigation, such action is required to be reported without further review or due process to the NPDB and the appropriate State Licensing Boards. **NOTE:** *Delete this paragraph if practitioner is not a physician or dentist.*

It is the policy of VA to report to State Licensing Boards those licensed health care professionals, whether currently employed or separated (voluntarily or otherwise), whose clinical practice during VA employment so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients (see title 38 Code of Federal Regulations Part 47). In the event you are found to not meet standards of care, consideration will be given whether, under these criteria, you should be reported to the appropriate State Licensing Board(s) pursuant to the provisions of VHA Handbook 1100.18,

Reporting and Responding to State Licensing Boards.

Sincerely yours,

Chief of Staff

**NOTE:** *The general statement of reason for review should be sufficient to enable the professional to understand what actions were involved and the nature of the concerns that have arisen from the actions.*

*a. The Advisement is to be mailed by Certified Mail, Return Receipt Requested, or hand delivered. The professional needs to sign a copy of the Advisement as an acknowledgement of receipt or there must be other evidence of receipt.*

*b. Consideration must be given to whether a personnel action also should be taken. Where a disciplinary or adverse action is warranted, the action to reduce or revoke privileges should be combined with the due process for the personnel action. Revocation of privileges requires removal from both employment appointment and appointment to the medical staff unless there is a basis to reassign the practitioner to a position not requiring clinical privileges*

*c. When revocation of privileges is proposed for permanent employees appointed under Title 38 United States Code 7401(1), based on professional conduct or competence grounds, the due process procedures for revocation of privileges must be combined with a proposed removal action. The notice letter for the removal action should advise that if a reduction or revocation of clinical privileges is effected based on the outcome of the dismissal proceedings, VA will file an adverse action report with the NPDB, with a copy to the State Licensing Board(s) in all States in which the practitioner holds a license and in the State in which the facility is located.*