CREDENTIALING AND PRIVILEGING

1. REASON FOR ISSUE. This revised Veterans Health Administration (VHA) Handbook provides VHA procedures regarding credentialing and privileging.

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

a. Incorporates VHA policy concerning VetPro; the Expedited Medical Staff Appointment Process; credentialing during activation of the facility Disaster Plan; requirements for querying the Federation of State Medical Boards (FSMB); and credentialing and privileging requirements for Telemedicine and remote health care.

b. Incorporates clarifications for the Summary Suspension of Privileges process in order to assure both patient safety and practitioner rights.

c. Defines the requirements to ensure complete, accurate and timely credentialing data at the time practitioners report for duty.

d. Incorporates the licensure requirements for compliance with Title 38 United States Code (U.S.C.) 7402, Qualifications of Appointees, which was amended in accordance with Public Law 106-117, Section 209.

e. Incorporates the credentialing requirements for physician assistants (PAs) and advanced practice registered nurses (APRNs).

f. Clarification that information protected by 38 U.S.C. 5705 is not to be used in the reappraisal and privileging process.

3. RELATED ISSSUE. VHA Directive 1100 (to be published).

4. RESPONSIBLE OFFICE. The Office of Quality Performance (10Q), is responsible for the contents of this VHA Handbook. Questions may be addressed to 919-993-3035, extension 236.

5. DOCUMENTS RESCINDED. VHA Handbook 1100.19, dated March 6, 2001, VHA Directive 2001-022, VHA Directive 2001-055, VHA Directive 2002-042, and VHA Directive 2002-076 and, are rescinded.

6. RECERTIFICATION. This VHA Handbook is scheduled for recertification on or before the last day of October 2012.

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CREDENTIALING AND PRIVILEGING

1. PURPOSE

This revised Veterans Health Administration (VHA) Handbook provides updated VHA procedures regarding credentialing and privileging, to include incorporating: VHA policy concerning VetPro; the Expedited Medical Staff Appointment Process; credentialing during activation of the facility Disaster Plan; requirements for querying the Federation of State Medical Boards (FSMB); credentialing and privileging requirements for Telemedicine and remote health care; clarifications for the Summary Suspension of Privileges process in order to ensure both patient safety and practitioner rights; and the credentialing requirements for physician assistants (PAs) and advanced practice registered nurses (APRNs). The credentialing, but not privileging, requirements of this Handbook apply to physicians, dentists, and other practitioners allowed by law and the facility to practice independently who are assigned to Research or administrative positions not involved in patient care. This Handbook does not apply to residents, except those who function outside the scope of their training program; i.e., as Admitting Officer of the Day.

2. 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 the 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 licensed independent practitioners permitted by law and facility to provide direct patient care, 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 portions of this Handbook specific to credentialing also apply to all APRNs and PAs for whom credentialing, but not privileging, is required, even though these practitioners are not practicing as licensed independent practitioners.

b. Policy and procedures related to the denial, failure to renew, reduction, and revocation of clinical privileges, where 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 providers who are granted clinical privileges or 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 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 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 and facility Directors who are involved in patient care. Differences in specific procedures are noted where applicable.

f. This policy applies to licensed health care personnel in VHA Central Office, Veterans Integrated System Network (VISN) offices, and other organizational components. ***NOTE:*** *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 center Medical Staff Bylaws, Rules, and Regulations can have any effect inconsistent with, or otherwise be inconsistent with, law, VA regulations, this Handbook's policies and procedures, or other VA policies.

3. 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 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; and 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 not be used for final verification.*

d. **Credentialing.** The term "credentialing" refers to the systematic process of screening and evaluating qualifications and other credentials, including 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 and provider-specific.

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

f. **Competency.** Competency is 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 FSMB or the National Practitioner Data Bank (NPDB) – Health Integrity and Protection Data Bank (HIPDB) 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, NPDB-HIPDB queries, and other credentials with expirations.

h. **Independent Practitioner.** The term "independent practitioner" is any individual permitted by law (the statute which defines the terms and conditions of the practitioner's license) 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 in an occupation, as evidenced by documentation issued by a State, Territory, Commonwealth, or the District of Columbia (hereafter, "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, if performed by more than one service, must be the same.

k. **PG.** The term PG means post-graduate.

l. **Primary Source Verification.** Primary source verification is 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 the ***NOTE*** following subpar. 6i(2) for additional information).

n. **Teleconsulting.** Teleconsulting is the provision of advice on a diagnosis, prognosis, and/or therapy from a licensed independent provider to another licensed independent provider using electronic communications 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 licensed independent health care provider.

o. **Telemedicine.** Telemedicine is the provision of care by a licensed independent health care provider that directs, diagnoses, or otherwise provides clinical treatment delivered using electronic communications and information technology when distance separates the provider 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 provider 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. A Medical Staff appointment is required if the provider 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 providers that facilitates completion of a uniform, accurate, and complete credentials file.

4. RESPONSIBILITIES

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

b. **Deputy Under Secretary for Health for Operations and Management (10N).** The Deputy Under Secretary for Health for Operations and Management (10N), is responsible for ensuring that VISN Directors maintain an appropriate credentialing and privileging process consistent with the VHA policy. In doing so, uniform prototype performance standards will be issued for key VHA medical facility managers, such as Directors, Associate and/or Assistant Directors, Human Resource Management Officers, and Chiefs of Staff (COS). Monitoring of credentialing and privileging must continue through periodic TJC consultative site visits and other reviews, as applicable.

c. **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:

(1) The labor-management obligations are met prior to implementing a Credentialing and Privileging Program that involves Title 5 independent practitioners who are represented by a professional bargaining unit.

(2) Local facility policy, including Medical Staff Bylaws, Rules and Regulations, is consistent with this Handbook.

d. **Facility COS.** The facility COS is responsible for maintenance of the credentialing and privileging system and must ensure that all health care professionals applying for clinical privileges agree to provide continuous care to the patients assigned to them and are provided with a copy of, and agree to abide by the Medical Staff Bylaws, Rules, and Regulations; and ensuring that the Medical Staff Bylaws are consistent with this Handbook and any other VHA policy related to Medical Staff Bylaws.

e. **Service Chiefs.** Service chiefs are responsible for:

(1) Recommending the criteria for clinical privileges that are relevant to the care provided in the service;

(2) Reviewing all credentials and requested clinical privileges, and for making recommendations regarding appointment and privileging action; and

(3) A continuous surveillance of the professional performance of those who provide patient care services with delineated clinical privileges. ***NOTE:*** *The title Service Chief applies to Service Line Directors, Product Line Chiefs, and any other equivalent titles.*

f. **Director, Management Review Service (10B5).** 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).

g. **Applicant and Practitioner.** Applicants and appointed practitioners must provide evidence of licensure, registration, certification, and/or other relevant credentials, for verification prior to appointment and throughout the appointment process, as requested. They must agree to accept the professional obligations delineated in the Medical Staff Bylaws, Rules, and Regulations provided to them. They are responsible for keeping the Department of Veterans Affairs (VA) apprised of anything that would adversely affect or otherwise limit their clinical privileges.

NOTE: *Failure to keep VA fully informed on these matters may result in administrative or disciplinary action.*

5. 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 5o, 6e, and 6f.

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 5a., 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 will be carefully considered before appointment and privileging decision actions are made.

(2) The applicable service chief reviews the credentialing folder and requested privileges and makes recommendations regarding appointment. The folder and recommendations are reviewed by the credentialing committee and then submitted with recommendations to the Executive Committee of the Medical Staff.

(3) All applicants applying for clinical privileges must be provided with a copy of the Medical Staff Bylaws, Rules, and Regulations and must agree in writing 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 frame, 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 appropriate forms for the position for which they are applying.

(1) All candidates, requiring credentialing in accordance with this policy, must complete an electronic submission of VetPro. VetPro's supplemental information form requests applicants to answer questions to meet TJC and VHA requirements. This supplemental information form requires the applicant to provide information concerning malpractice, adverse actions against licensure, privileges, hospital membership, research, etc.

(2) The "Sign and Submit" screen in VetPro addresses the applicant's agreement to provide continuous care and to accept the professional obligations defined in the Medical Staff Bylaws, Rules, and Regulations for the facility(s) to which the application is being made, as well as attesting to the accuracy and completeness of the information submitted.

(3) An applicant is required to provide information on all educational, training, and employment experiences, including all gaps greater than 30 days in the candidate’s history.

(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, current competence, and supplemental questions. The updated information must be verified prior to the candidate reporting for duty. Verification of a time-limited credential cannot be greater than 120 days old at the time a practitioner reports for duty. This requirement includes a response from the NPDB–HIPDB. ***NOTE****: Delays between the 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.*

NOTE: *A copy of the appropriate application form and any supplemental form(s) are maintained electronically in VetPro and may be filed in Section I of the credentialing and privileging folder. If the applicant provides a resume or curriculum vitae, this is also filed in Section I.*

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 necessary and is discouraged.*

(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. Facilities are expected to secure all credentialing and privileging documents. Any facsimile copy must be followed up with an original document. ***NOTE:*** *When using an Internet source for verification, the following criteria must be considered in determining appropriateness as primary source verification: (a) 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 seriously be considered as not adequate for verification. (b) 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 primary source verification or the transmission is in an encrypted format. (c) The site must provide information on the status of license and adverse action information. (d) To avoid issues arising with surveyors, it is advisable to print the disclaimer when the verification is printed. Sites are <u>constantly</u> 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 previously provided information was not correct. Follow-up with the verifying entity will be 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, or designee, of any changes in the status of these credentials. The facility 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. The practitioner is required to provide a written explanation for any credentials that were held previously, but which are no longer held, or are no longer full and unrestricted. The verifying official must contact the State board(s) 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, should 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 documents is unsuccessful or 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, will be placed in the folder in lieu of the document sought. It is suggested that no more than 30 days elapse before the attempt is deemed unsuccessful. The practitioner should be notified and assist in obtaining the necessary documentation through a secondary source.

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, 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 will be necessary to obtain primary source verification of the internship(s). 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) All efforts to verify education must be documented if it is not possible to verify education, 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 in educational history. 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, 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 providers, 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, the qualifying degree for the registered nurse (RN) and the advanced APRN education must be verified).

(g) Primary source verification of other advanced educational and clinical practice program 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. The AMA Physician Masterfile is a TJC-designated equivalent for primary source verification requirements for physicians' and osteopaths' education and completion of residency training. ***NOTE:*** *The AOA Physician Database is a designated equivalent for pre-doctoral education accredited by the AOA Bureau of Professional Education, postdoctoral education approved by the AOA Council on Postdoctoral Training, and Osteopathic board certification.* In instances where these profiles do not stipulate primary source verification was obtained, the facility must pursue that verification if required by this policy. 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 Section III of the Credentialing and Privileging Folder and in the appropriate portion of VetPro.

f. **Verifying Specialty Certification**

(1) **Physician Service Chiefs**

(a) 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 appropriate for the assignment, the medical staff's Executive Committee 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 provider specific data. Appointment of service chiefs without board certification will comply with the VHA policy for these appointments as appropriate.

(b) 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).

(2) **Physicians**. Board certification may be verified through the Official ABMS Directory of Board Certified Medical Specialists, published by the American Board of Medical Specialists (ABMS), or 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 American Osteopathic Association 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.*

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

(4) **Podiatrists**. Three specialties 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.*

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

(6) **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.

(7) **Filing**. Verification of specialty certification is filed in Section III of the Credentialing and Privileging folder and 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.) Section 7402(f).** Applicants being credentialed for a position identified in 38 U.S.C. Section 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, who have had such 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 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 does verify 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 provider 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 section of the credentials file.

(e) This policy applies to licensure, registration, or certification required, as applicable, to the position subsequent to the publication of this policy and required by statute or VA qualification standards, effective with the date the credential is required.

(3) 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, 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.*

(4) **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, 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 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.

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 A, subparagraphs 13f and 13g.*

(5) SLBs may restrict the license of a practitioner for a variety of reasons. Among other restrictions, an SLB may suspend the licensee's ability to independently prescribe controlled substances or other drugs; selectively limit one's authority to prescribe a particular type or schedule of drugs; or accept one's offer or voluntary agreement to limit 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.*

(6) 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.

(7) **Physician Applicants**. Physician applicants including physician residents who function outside of the scope of their training program, i.e., who are appointed as Admitting Officer of the Day, must be screened with the FSMB prior to appointment.

(a) The FSMB is a disciplinary information service and reports only those disciplinary actions resulting from formal actions taken by reporting medical licensing and 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.*

(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 5o, 5p, 6e, and 6f.

(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 will 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 will 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. 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.

(8) **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 probational status, or denied upon application, may be appointed under the appointment procedures that apply to other physicians and 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 5g(1) and 5g(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 Credentialing and Privileging folder and the appropriate section of VetPro.

(d) Subject to the restrictions in preceding subparagraph 5g(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. 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 Chief Medical Officer for concurrence and approval of the appointment. All associated documentation must be filed in the Credentialing and Privileging folder and the appropriate section of VetPro.

(9) **Verification with SLB(s).** Verification 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. At the request of the COS, the facility Director may delegate responsibility for contacting SLBs. If the State is unwilling to provide primary source verification of licensure, the facility must document the State's 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.*

(10) **Filing.** Verification of licensure and/or registration must be filed in Section IV of the Credentialing and Privileging folder and in the Licensure portion of VetPro.

h. **Drug Enforcement Agency (DEA) Certification**

NOTE: *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. Questions regarding whether the facility's institutional DEA certification with a suffix meets the State's requirement for individual certification are to be directed to Regional Counsel.*

(1) **Background.** Physicians, dentists, and certain other professional practitioners may apply for and be granted renewable certification by the Federal and/or State DEA, 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 certification. Individual certification by DEA is not required for VA practice, since practitioners may use the facility's institutional DEA certificate with a suffix.

NOTE: *In order to prescribe controlled substances, contract licensed health care professionals who practice outside VA facilities must possess individual DEA registration in the State of practice. In order to obtain such individual DEA registration in the State of practice, the practitioner needs to be licensed by that State. However, contract licensed health care professionals who are practicing within VA facilities may rely on the facility's institutional DEA certification with a suffix.*

(2) **Application.** Each applicant possessing a DEA certificate must document information about the current or most recent DEA certificate on the appropriate VA application form. Any applicant whose DEA 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 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) **Verification**

(a) A copy of the current Federal DEA certification must be sighted 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 and filed in Section IV of the standard credentialing and privileging folder.

(b) Verification of a State DEA or Controlled Dangerous Substance (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 no 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 Section IV of the standard Credentialing and Privileging folder and 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. All references must be documented in writing. Written records of telephone or personal contacts must include who was spoken to, 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 the Credentialing and Privileging folder. 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. ***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, and 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. As appropriate to the occupation for which the applicant is being considered, references need to

contain specific information about the individual's scope of practice and level of performance. 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 clinical judgment and technical skills 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, whether paid or appointed, have a new appointment after a break in service, or are on a WOC basis, who request clinical privileges, including those utilized on a full-time, part-time, or intermittent basism as consultants or attendings; or on a fee-basis, and including those utilized on an on-station contract or on-station sharing agreement basis are required to declare on the appropriate health status form that there are no physical or mental health conditions that would adversely affect ones 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 Section V of the Credentialing and Privileging folder and 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 Section VI of the Credentialing and Privileging folder and in the Supplemental Section of the VetPro file.

(3) **Primary Source Information.** Efforts should 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 will consider VA's obligation as a health care provider 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 are to be documented in the Supplemental 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 Section VI of the credentialing and privileging folder and the appropriate section in VetPro. 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 needs to be directed to the Regional Counsel or General Counsel.*

l. **NPDB – HIPDB Screening**

(1) Proper screening through the NPDB-HIPDB is required for applicants, including physician residents who function outside of the scope of their training program, i.e., those appointed as Admitting Officer of the Day, 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:

(a) Prior to appointment, including reappointment and transfer from another VA facility, whether or not VA requires licensure for appointment, reappointment, or transfer;

(b) Every 2 years following appointment or reappointment; and

(c) Any time a clinical privilege application is made, including a request for additional privileges, regardless of the time since the previous NPDB-HIPDB query or privileges were granted.

NOTE: *If currently detailed to another VA facility or serving another facility as a consultant, the receiving facility must query NPDB-HIPDB.*

(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 query the NPDB-HIPDB combined query 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 Admitting Officers of the Day.*

(3) VetPro maintains evidence of query submission and response received, as well as any reports obtained in response to the query and meets the NPDB-HIPDB requirement. For those queries not done through VetPro, evidence of query submission will be retained in the Credentialing and Privileging file until receipt of the NPDB-HIPDB screening results.

(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.

(5) Screening applicants and appointees with the NPDB-HIPDB 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 5k(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 screening information is filed in Section VI of the Credentialing and Privileging folder and the appropriate section of 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 should be appointed only after a query to the NPDB-HIPDB has been initiated. Queries need not be initiated prior to the applicant's submission of a complete application. When all other credentialing procedures have been completed, if for some documented reason, an NPDB-HIPDB query has been made and a response not received, the facility may appoint the applicant. ***NOTE:*** *If adverse information is uncovered, facility officials must decide whether to separate the practitioner based on suitability.*

(2) Title 38 candidates may be appointed on a time-limited basis under 38 U.S.C. 7405, while waiting for NPDB-HIPDB reports. Health care professionals appointed on a full-time, part-time or intermittent basis may generally be given appointments for more than 1 year, e.g., 13 months, to permit them to receive benefits while on the temporary appointment. Once reports are received and all questions regarding suitability for appointment are resolved, candidates may be converted to probationary or permanent appointments under 38 U.S.C. 7401(1), 7401(3), or to other appointments under 38 U.S.C. 7405, as appropriate.

(3) Scarce medical specialty contracts and sharing agreements may be put into effect pending reports regarding contract providers. If the NPDB-HIPDB query generates negative information that requires modification of the contract, Federal Acquisition Regulations (FAR) and VA Acquisition Regulations (VAAR) must be followed.

(4) **Appointment After Reports Received.** If there is no evidence of disciplinary action by any SLB, adverse action taken against clinical privileges, adverse action regarding professional society membership, medical malpractice payment for the benefit of the practitioner, or Federal health care program exclusion, the screen results must be maintained in VetPro with supporting information filed in the Credentialing and Privileging file, and facility officials will proceed with the appointment under appropriate authority.

(5) If the NPDB-HIPDB screen shows action in any of the areas listed in the preceding paragraph, 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. The practitioner may be employed or continued in employment only after applicable procedural requirements are met. 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 report is maintained electronically in VetPro. Other reports not obtained through VetPro and all related documents are to be filed in the Credentialing and Privileging folder.*

(a) If an NPDB-HIPDB report indicates any multiple of the following actions, requirements for each 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 must be included in the credentialing information.

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 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 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 and 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 could result in a decision to:

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

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

3. Not appoint or terminate.

(c) Once requirements for consideration and evaluation of any action reported by NPDB-HIPDB have been completed, 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 Handbook 5021, as they apply to the category of practitioner.

(d) When any initial, biennial or other 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 Materiel Management Service) to ensure that they are processed in accordance with applicable requirements.

n. **Credentialing and Privileging 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) will ensure appropriate mechanism are in place for verifying and undertaking privileging of off-site providers who deliver services via telemedicine/teleconsultation both at the site providing telemedicine/teleconsultation and the site receiving these services, in order to assure that the care delivered fits within the resources of the facility(s) and scope of practice of the practitioners.

(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. This ensures that mechanisms are provided for appropriate appointment, credentialing, and privileging of providers both at the site providing the telemedicine and/or teleconsultation and at the site receiving these services in order to ensure the care delivered fits within the resources of the facility and scope of practice of the practitioners.

(b) The practitioner providing the telemedicine and/or teleconsultation services must be credentialed and privileged in accordance with this Handbook.

(2) **Teleconsultation.** The practitioner providing only teleconsultation services must be appointed, credentialed, and privileged at the site at which the practitioner is physically located when providing teleconsultation services.

(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 5n.(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 licensed independent privileged provider, 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 via a telemedicine link, 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 Questions, licensure verification, confirmation of current competency, and an 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 should include the appropriateness of using telemedicine to deliver services and consider 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 query the NPDB-HIPDB. The NPDB-HIPDB query must be repeated in accordance with credentialing and reappraisal requirements of this policy, at a minimum of every 2 years. ***NOTE:*** *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.** 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/teleconsultation services.

NOTE: *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 Regional Counsel needs to be sought in these matters.

o. **Expedited Appointments to the Medical Staff.** There may be instances where expediting a medical staff appointment for licensed independent providers 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 licensed independent provider completes the credentials package, including but not limited to, a complete application; therefore, the provider must submit this information through VetPro and documentation of credentials must also 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 5g).*

c. Confirmation on 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 Action Data Center with no report documented;

e. Confirmation from two peer references who are knowledgeable of and confirm the physician's competence, including at least one from the current or most recent employer(s) or institution(s) where the applicant holds or held privileges, or who would have reason to know the individual's professional qualifications.

f. Current comparable privileges held in another institution; and

g. NPDB-HIPDB query 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 30 workdays 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 if the application is not complete (including answers to Supplemental Questions, Declaration of Health, and Bylaws Attestation); or if there are current or previously successful challenges to licensure; ANY history of involuntary termination of medical staff membership at another organization, involuntary limitation, reduction, denial, or loss of clinical privileges; or 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 45 workdays for the completion of the full credentialing process begins with the date of the 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 healthcare program funds for items or services he or she 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 providers 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 45 calendar days. It may not be extended or renewed. The complete appointment process must be completed within 45 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 45 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 providers 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 licensed independent practitioner 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.

(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 with no match;

(d) Response from FSMB with no reports;

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

(f) Documentation by the facility Director of the specific patient care situation that warranted such an appointment.

(4) Temporary appointments must be completed in VetPro including the NPDB-HIPDB query 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 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 will 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 will 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 subparagraph 6e).*

q. **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. 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); NPDB-HIPDB query 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 facility Director or designee of any changes in the status of these credentials at the earliest date after notification is received by the individual.

(2) If at any time, after the initial appointment, it is noted that a provider 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 subparagraph 5g).

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 facility 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) 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).

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

r. **Transfer of Credentials.** When practitioners are assigned to more than one health care facility for clinical practice, the "primary" or originating facility must convey all relevant credentials information to the gaining or satellite facility. This may be accomplished by forwarding an authenticated true copy of the Credentialing and Privileging folder to the receiving facility. The VetPro electronic credentials file must be shared with the gaining or satellite 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 same. ***NOTE:*** *The gaining facility must query the NPDB-HIPDB, 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.*

s. **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 Federal Records Center (FRC) 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.*

(2) When a VA practitioner transfers from one VA facility to another, the original Credentialing and Privileging folder needs to be transferred to the gaining facility immediately upon transfer. ***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.*

(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.

6. PRIVILEGING

NOTE: *Paragraph 6 contains the administrative and clinical requirements and procedures relating to the granting of clinical privileges, appraisal and re-privileging, and reduction and revocation of privileges.*

a. **Provisions**

(1) Privileges must be facility 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.

NOTE: *The delineation of clinical privileges must be: facility specific, setting specific, and provider specific.*

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 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 will be granted according to the procedures delineated within this Handbook which must be reflected in the 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 2-year period, which begins from the date the privileges are signed, dated, and approved by the facility Director. However, clinical privileges granted to contractors may not extend beyond the contract period. Each new contract period requires reappraisal and re-privileging. 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 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 least:

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. 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.

(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; they are based on credentials and performance and authorized by the facility.

(a) The criteria for the delineation of privileges are determined by the individual services, recommended by the Executive Committee of the Medical staff as defined in the Medical Staff Bylaws, and approved by the facility Director. These criteria and delineated privileges are to be reviewed on a regular basis as defined in the Medical Staff Bylaws.

(b) Privileges granted to an applicant must be facility specific, based on 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 the process for granting privileges by any combination of level of training and experience, patient risk categories, and lists 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 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 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 medical staff's Executive Committee.

(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.

(4) **Setting Specific Privileges.** The settings in which care is delivered dictate the type(s) of care, treatment, and services or procedures that a practitioner will be authorized to perform. Privileges are setting specific, within the context of each facility, requiring consideration of each unique setting's characteristics, such as adequate facilities, equipment, and number and type of qualified support personnel and resources. Setting-specific privileges are granted based on the practitioner's qualifications, and also on consideration of the procedures and types of care, treatment, and services that can be performed or provided within the proposed setting.

NOTE: *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. 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 establish possession of the appropriate 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 least, a list of the documents reviewed and the rationale for the conclusions. The service chief recommends approval, disapproval, or a modification of the requested clinical privileges. This recommendation may include a limited period of direct supervision, or proctoring, by an appropriately-privileged practitioner for privileges when a practitioner has had a lapse in clinical activity, or for those procedures that are high risk as defined by medical center policy.

(3) Subsequent to the service chief's review and recommendation, the request for privileges, along with the appointment recommendation of the Professional Standards Board (PSB) or credentialing committee (if applicable), must be submitted to the medical staff's Executive Committee for review. The medical staff's Executive Committee evaluates the applicant's credentials 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. A final recommendation is then submitted to the facility Director.

(4) Residents who are appointed, outside of their training program, to work on a fee basis as Admitting Officer of the Day must be licensed, credentialed, and privileged for the duties they are expected to perform. 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. The term "resident" also includes health care professionals in advanced PG education programs who are typically referred to as "fellows."

(5) Copies of current clinical privileges must be available to hospital staff on a need-to-know basis in order to ensure providers 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 provider 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). The mechanism is to be concurrent with exercise of privileges, not retrospective. ***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 will chair the medical staff's Executive Committee and the COS will be absent from the deliberations. The medical staff's Executive Committee recommendations regarding approval of requested privileges will be submitted directly to the facility Director for action.

(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 Chief Medical Officer (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 medical staff's Executive Committee 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 5r. Other than teleconsultation, in all cases, 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 NPDB-HIPDB query initiated.

(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 (see subpar. 6h(1)).

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. 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 and emergency management plan, the emergency management plan has been activated, and the facility is unable to handle the immediate patient needs. 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 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.

(4) 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.

(5) A specified period of time 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 relieved.

(6) A defined process 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. **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. However, reappraisal may be required more frequently for contractors, depending upon the length of the contract period.

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;

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;

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.

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 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 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.

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. 5g).*

2. Additional information regarding licensure and/or registration status, NPDB-HIPDB querying 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, Proficiency Reports, or VA Form 3482b, Performance Appraisal, 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 provider-specific performance improvement activities. 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. The individual providers' profiles may include provider-specific, non 38 U.S.C. 5705-protected data when applicable. For example, the provider-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 provider 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 providers with comparable or similar privileges.

NOTE: *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. However, clinical privileges granted to contractors may not extend beyond the contract period. Each new contract period requires reappraisal and re-privileging. 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) 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 hospital, 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.

(c) 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 for review and recommendation. The decision of the medical staff’s Executive Committee 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.

(d) 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.

(e) 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 a query to the NPDB-HIPDB will 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 folder must be presented to the appropriate service chief for review. The service chief considers the additional information and the entire Credentialing and Privileging folder before making a recommendation to the medical staff's Executive Committee. The medical staff's Executive Committee then presents a recommendation to the facility Director for action.

(f) 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 medical staff's Executive Committee recommendations related to the approval of the requested privileges must be submitted directly to the facility Director for action, or to the Associate Director who is authorized to act as facility Director for this purpose.

h. **Denial and Non-Renewal of Privileges.** This paragraph defines policy and 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 and privileging folder, 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 folder, 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 only reports to the NPDB adverse privileging actions against physicians and dentists. See VHA Handbook 1100.17 and 38 CFR Part 46.*

NOTE: *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 and 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 therefore must be rediscovered through the administrative review or investigation process.*

i. **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, the action against the privileges is to be incorporated into the due process procedures provided for the disciplinary or adverse personnel action.

NOTE: *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 is a reduction of privileges 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 reprivileging process. Data gathered in conjunction with 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 administrative reviews and 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.

NOTE: *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.*

(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.

(c) 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.

(d) A practitioner 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.

NOTE: *Due process under these circumstances is limited to a hearing to determine whether the practitioner'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.

(e) Adverse professional review action. Any 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 practitioner 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 an action may result in an imminent danger to the health of any individual. Summary suspension pending comprehensive review and due process, as outlined in subparagraph 6i, on reduction and revocation, is not reportable to the NPDB. However, the notice of summary suspension to the practitioner 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.

a. When privileges are summarily suspended, the comprehensive review of the reason for 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 the facility Director for consideration and action. The Director will make a decision within 5 working 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 should be sought from Regional Counsel and Human Resources to ensure due process is afforded. It is only after the due process is completed and 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. 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. **Independent Contractors and/or Subcontractors**

a. 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 VHA Credentialing and Privileging policy regarding reduction and revocation of privileges, prior to reporting the 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 for possible incompetence or improper professional conduct, thereby automatically revoking the medical staff appointment and associated clinical privileges of the contractor and/or subcontractor;

(2) Where the contractor and/or subcontractor terminates the contract or subcontract, thereby surrendering medical staff appointment and associated privileges, either while under investigation relating to possible incompetence or improper professional conduct; and

(3) Where VA terminates the services (and associated medical staff appointment and clinical privileges) of a subcontractor under a continuing contract for possible incompetence or improper professional conduct.

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

c. Where a contract is renewed or the period of performance extended, the contractor and/or subcontractor 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 reverified.

3. **Automatic Suspension of Privileges.** Privileges may be automatically suspended for administrative reasons which may occur in instances where the provider is behind in dictation, or allowed a license to lapse and therefore does not have an active, current, unrestricted license.

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 practitioners services needs to be performed and documented and appropriate action taken. Any action is to be reviewed against all reporting requirements.

(f) 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.

(4) **Reduction of Privileges**

(a) Initially, the practitioner receives a written notice of the proposed changes in privileges from the COS, which notice must include a discussion of the reason(s) for the change. The notice also needs to indicate that if a reduction or revocation is effected based on the outcome of the proceedings, 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.

(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 workdays of the COS's written notice. If requested by the practitioner, the COS may grant an extension for a brief period, normally not to exceed 10 additional workdays, 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) All information is forwarded to the facility Director for decision. 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 workdays after receipt of decision.

(d) The facility Director must appoint a review panel of three professionals, within 5 workdays after receipt of the practitioner's request for hearing, to 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.

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 workdays and not more than 30 workdays 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 workdays 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 workdays 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 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 workdays 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 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 workdays after receipt of the practitioner's appeal.

NOTE: *The decision of the VISN Director is not subject to further appeal.*

(5) **Revocation of Privileges**

(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 appointment 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, 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 without further review or due process to the NPDB.

NOTE: *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 Department in a timely manner. An advance review by 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.

NOTE: *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.*

NOTE: *Practitioners, 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.*

(c) For probationary employees appointed under 38 U.S.C. 7401(1), the proposed revocation requires probationary separation procedures contained in VA Handbook 5021. 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 probationary or temporary employee must be provided with the due process procedures that are provided for reduction 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). 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. Practitioners 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.

(d) When the revocation of privileges is proposed for practitioners not covered under subparagraphs 6i(3)(b) and 6i(3)(c), consideration must be given to discharging or removing the practitioner, as applicable. It may be desirable to consider other alternatives, such as demotion or reassignment to a position that does not require privileges, where appropriate.

NOTE: *Revocation procedures will 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.*

(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 Handbook 5021, when this is determined to be in the best interests of VA.

j. **Inactivation of Privileges.** The inactivation of privileges occurs when a practitioner is not be an active member of the medical staff. It is difficult to quantify "extended period of time," but facilities need to consider 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 as an extended period of time. 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 providers 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.

NOTE: *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.*

NOTE: *Medical staff appointments and privileges will not be granted for a period longer than the formal relationship with the facility. For example, if a contract has a finite end date, privileges may not be granted past the end date of the contract regardless of intent to renew. If a contract is terminated prior to expiration of the contract, privileges must be terminated since there is no legal agreement for the practitioner to be providing care. Where the contract 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. Where substandard care, professional incompetence, or professional misconduct is not involved in the early termination of the contract, privileges must be terminated without regard to the due process requirements for privileging actions. This termination is not reportable to the NPDB.*

k. **Deployment and/or Activation Privilege Status.** In those instances where a provider is called to active duty, the provider'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 providers before deployment.

(1) Providers 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 provider must update the electronic Credentials File in VetPro 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 provider performed clinical work while on active duty, an attempt must be made to confirm the type of duties, the provider'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 medical staff’s Executive Committee for review and recommendation. The decision of the medical staff’s Executive Committee must be documented (the minutes must reflect the documents reviewed and the rationale for the stated conclusion) and forwarded to the facility Director for recommendation and approval of restoring the provider'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 provider 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 provider was not providing clinical care while on active duty, the provider in cooperation with the Service Chief, Clinical Executive Board, 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 facility 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) A response from the NPDB-HIPDB with no match.

(c) A response from the FSMB with no match.

(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 provider from returning to the medical center in accordance with Uniformed Services Employment and Reemployment Rights Act of 1994.*

7. 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 facility 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 also comply with all other timeframes established in this policy (see subpar. 5c(4)).*

c. The type of employment appointment, i.e., full-time, part-time, WOC, consultant, contract, fee basis, sharing agreement, or other needs to 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. If at the time of initial evaluation, 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 provider holds a medical staff appointment needs to start the re-privileging process.

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

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

(b) They should only need to submit their renewal application in VetPro once, and

(c) It is important that they 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 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, 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 query the NPDB-HIPDB.

(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 notify all facilities that share the provider 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 appointments with no change in privileges.

(1) In those instances where a provider has held a specific employment or medical staff appointment and is being converted to a different type of appointment, either medical staff appointment or Title 38 appointment, the practitioner applies for this appointment.

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

(3) The NPDB-HIPDB must be queried.

(4) The information obtained in this process will 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.

8. REFERENCES

a. Title 38 U.S.C. 5705.

b. Title 38 U.S.C. 7304, 7401(1)(2)(3), 7402, 7405, 7409, and 7461 through 7464.

c. Title 45 CFR Part 60.

d. Public Laws (Pub. L.) 99-166 and 99-660 and its revisions.

e. Pub. L. 100-177.

f. Pub. L. 106-117, Section 209.

g. Pub. L 105-33, Section 4331(c).

h. Pub. L 104-191, Section 221.

i. Title 38 CFR Part 46.

j. Title 5 CFR Parts 315, 731, and 752.

k. VA Handbook 5005.

l. VA Handbook 5007.

m. VA Handbook 5021.

n. VHA Handbook 1100.17.

o. VHA Handbook 1100.18.

p. Joint Commission on Accreditation of Healthcare Organizations, Comprehensive Accreditation Manual for Hospitals.

q. Privacy Act System of Records Notice for Healthcare Provider Records (77VA10Q).

STANDARD (SIX-PART) 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 by the Chief Medical Director (now the Under Secretary for Health) on April 9, 1991, represents a practitioner who has held appointment or 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 and Reappraisal Information.

(2) Section II. Clinical Privileges.

(3) Section III. Professional Education and Training.

(4) Section IV. License(s).

(5) Section V. Professional Experience.

(6) Section VI. Other Practice Information.

b. Sections I and II provide for a complete overview of the individual practitioner's qualifications, type of appointment and clinical privileges. Sections III through VI represent the support documents to the information presented in Sections I and II. All documents are to be filed in the order specified.

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.

Occupation	Series	L, C, Date 1st Required
Chiropractor		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 a licensed independent provider, but still subject to Title 38 United States Code (U.S.C.) 7402(f)

3. There are a number of professions both on this list and not found on this list, but identified in paragraph 2 of this Attachment 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 via 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 providers 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 will 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 provider'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 will be 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."* If there is a match to the FSMB query, the response, a Portable Document Format (PDF) file, is retrievable through the VetPro *License* screen and it can be viewed when VetPro launches Adobe Acrobat 5.0 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 need to query must be in accordance with the following procedures (see App. D).

a. For those providers for whom there was a *Match* with the FSMB Disciplinary Files, reports were forwarded to the appropriate facility for scanning in to the VetPro *License* screen. For those providers who had not submitted credentialing information through VetPro when the report was returned to the facility it may have been screened 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 will 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 provider's record.

(3) VetPro receives the response from the FSMB and appends it to the VetPro *License* screen. If there is no match on the query, this will be displayed on the VetPro *License* screen similar to the no match response received from the NPDB stating *"No Match."* If there is a match to the FSMB query, the response, a PDF file is retrievable through the VetPro *License* screen and it can be viewed when VetPro launches Adobe Acrobat 5.0 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 center staff.

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

c. VetPro receives the response from the FSMB and appends it to the VetPro *License* screen. If there is no match on the query, this will be displayed on the VetPro *License* screen similar to the no match response received from the NPDB stating *"No Match."* If there is a match to the FSMB query, the response, a PDF file, is retrievable through the VetPro *License* screen and it can be viewed when VetPro launches Adobe Acrobat 5.0 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 will be documented each time on the VetPro *License* screen (see App. D). The only exceptions to this requirement are:

a. 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, 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 provider is appointed in VHA at a future time the practitioner's name will 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 Federa