HAWAII HEALTH SYSTEMS C O R P O R A T I O N *"Touching Lives Everyday"* **Policies and Procedures**	**Department:** Legal Department	**Policy No.:** **ADM 0017**
		Revision No.: N/A
	Issued by: Rene McWade, Esq. VP & General Counsel	**Effective Date:** 4/17/2008
Subject: ***Credentialing for Interpretative Reading Off-site Services***	**Approved by:** HHSC Board of Directors By: Raymond Ono Its: Secretary/Treasurer	**Supersedes Policy:** N/A
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I. DEFINITION: For the purposes of this policy, the term "Off-Site Services" refers to clinical services contracted by a facility of HHSC for the performance of interpretive services not on the physical campus of the hospital or via telecommunication mechanisms. Examples of interpretive reading of off-site services include radiology, cardiology, neurology and pathology.

II. PURPOSE: To provide clarification and guidance to credentialing requirements for providers performing interpretation within the scope of contracted off-site services. This policy is not applicable to telemedicine.

III. POLICY STATEMENT: When HHSC facilities contract for interpretive off-site services, licensed independent practitioners (LIPs) providing the service require appropriate privileges to be granted by the Governing Body if the service provided is impacts therapeutic treatment of patients.

IV. CONSIDERATION PROCEDURES:

A. If the contract is with a The Joint Comission (TJC) accredited organization, contract language will require use of LIPs credentialed and privileged to fulfill the contract.

B. In the absence of a contract or if the contract is with a non-TJC accredited entity or an individual practitioner, then the facility may credential the LIP using one of the following options:

a. Option 1 – Credentialing per the process established in the medical staff bylaws;
b. Option 2 – If the LIP providing the service holds privileges at a TJC accredited facility, completion of a Credentialing Transfer Form (attachment) and a current list of delineated privileges will suffice as verification of an applicants credentials. The LIP must be privileged at the accredited facility for the service to be provided to the HHSC facility.

CREDENTIALING TRANSFER FORM

NOTE: If any item is not verified by a primary source, list source used on separate page

1. PROVIDER'S NAME	1A. SOCIAL SECURITY #
1B. TYPE OF APPOINTMENT	1C. SPECIALTY

I. 2. EDUCATION AND TRAINING

	DEGREE OR SPECIALTY	INSTITUTION	LOCATION	COMPLETION DATE	PRIMARY SOURCE VERIFIED
EDUCATION					π YES π NO
INTERNSHIP					π YES π NO
RESIDENCY					π YES π NO
FELLOWSHIP					π YES π NO
(OTHER) _____					

3. ECFMG CERTIFICATE #	3A. ISSUE DATE	3B. VERIFIED π YES π NO

4. STATE MEDICAL LICENSE

STATE	LICENSE #	EXPIRATION DATE	PRIMARY SOURCE VERIFIED

5. DRUG ENFORCEMENT ADMINISTRATION (DEA) CERTIFICATE #	5A. EXPIRATION DATE
6. SPECIALTY BOARD CERTIFICATION	6A. EXPIRATION DATE
6B. SPECIALTY BOARD CERTIFICATION (OR SUBSPECIALTY)	6C. EXPIRATION DATE
7. CLINICAL PRIVILEGES GRANTED IN:	7A. EXPIRATION DATE
8. NATIONAL PRACTITIONER DATA BANK (NPDB) QUERY(IES) DATE; I.E., DATE SUBMITTED:	

9. (Insert provider's name)_____ attested to not having a physical or mental health condition that would adversely affect the ability to carry out the clinical duties requires from (insert name of hospital where currently appointed)_____; is known to be clinically competent to practice the full scope of privilege granted at this facility, to satisfactorily discharge professional and ethical obligations, as attested to by (insert name and telephone # of dept. chair), _____ and is known to be providing telemedicine services. (Insert dept. chair's name) _____ has additional information relating to (insert provider's name) _____ competence to perform granted privileges.

10. (Insert provider's name) _____ credentialing file and the documents contained therein have been reviewed and verified. The information conveyed in this transfer form reflects credentials status as of (insert date) _____. The credentialing file contains no additional information relevant to the privileging of the provider at your hospital.

11. MEDICAL STAFF OFFICE REPRESENTATIVE (Typed Name)	11A. TELEPHONE #	11B. FACSIMILE #
NAME OF FACILITY	SIGNATURE OF MEDICAL STAFF OFFICE REPRESENTATIVE	