Health Care Credentialing Glossary

ASA HEALTH CARE SECTION

An essential guide for American Staffing Association members to provide clarity and context for commonly encountered terms and acronyms in the health care credentialing space.

Health Care Credentialing Glossary*

Table of Contents

Section 1: Credentialing Documents 3

Section 2: Occupational Health Screening Requirements 6

Section 3: Payor (Insurance) Enrollment Terms..... 9

Section 4: Professional Councils, Government Agencies, and Associations 12

Appendix: Alphabetical Lists of All Terms 14

*The goal of this document is to provide clarity and context for commonly encountered terms and acronyms in the health care credentialing space. It is important to remember that staffing agencies, health care facilities, insurance payers, and health care practitioners may utilize terms in different ways and with varying definitions or standards of requirements. This is neither meant to be a comprehensive list of terms nor to provide direction on how to interpret or define terms for any facilities, agencies, or individuals; rather it is intended to be a high-level and introductory resource for those unfamiliar with health care credentialing. This glossary will be reviewed for accuracy and relevance annually and is expected to evolve just as the industry does. Thank you to all who have contributed thus far and to those who will do so in the future.

Section 1: Credentialing Documents

Advanced Cardiovascular Life Support (ACLS)— Certification attesting to a provider's training and competence utilizing a group of procedures and techniques that can treat life-threatening conditions, including cardiac arrest. Some versions are available as online-only courses, but many facilities require a course through the American Red Cross or the American Heart Association that includes a combination of classroom or online instruction and in-person skills assessments. Typically, good for two years after obtaining.

Advanced Trauma Life Support (ATLS)—Training and certification program for medical providers responding to acute trauma cases, originally developed by the American College of Surgeons.

Application—Any document used to gather information such as demographics, work history, affiliations, education, malpractice, background, and/or peer reference information. May include state-specific applications, facility applications, or agency onboarding applications.

Basic Life Support (BLS)—Training and certification for care that first responders, health care providers, and public safety professionals provide to anyone who is experiencing cardiac arrest, respiratory distress, or an obstructed airway. Many online-only options are available, though some facilities require a course through the American Red Cross or the American Heart Association that includes a combination of classroom or online instruction and in person skills assessments. Typically, good for two years after obtaining.

Board Certification—Refers to any number of professional board exams taken by various provider types and specialties to demonstrate proficiency in a specialized field of medical expertise. Commonly recognized board certifications come from American Board of Medical Specialties and the American Osteopathic Association for doctors (MD and DO), American Nurses Credentialing Center or the American Association of Nurse Practitioners for nurse practitioners, the National Commission on Certification of Physician Assistants for physician assistants, the American Board of Dental Specialties for dentists, and many more. Many facilities may not recognize all board certifications available to practitioners, so it's important to confirm what board certifications are expected and accepted by health care clients and facilities.

Case logs—Also referred to as procedure logs, patient contact volume reports, CPT, or ICD-10 codes, etc. Used to support clinical competency by demonstrating how often a provider performs a procedure, documents a diagnosis, or bills for a particular patient encounter type. Often required during the hospital privileging process.

Certificate of insurance (COI)—Provides record of current or previous malpractice coverage for a specific provider during a specific policy range (often one year) and indicates the policy number, carrier detail, and malpractice limits for each line of coverage shown.

Claims history or loss run report—A letter or report provided by a malpractice insurance carrier that provides feedback around any or all claims filed on a policy while a specific provider was covered.

Continuing Education Unit (CEU)—A unit of credit for educational offerings given to professional persons, determined by a professional organization according to a mathematical formula after a thorough review of the program of study, the qualifications of the instructors, and the program objectives. Often utilized for maintaining quality, knowledge, competence, and even credentialing requirements.

Continuing Medical Education (CME)—Credits for physicians and other licensed health care practitioners; used to demonstrate continued or increased proficiency during credentialing, licensing, or certifications processes. Often required during renewal of licensure or for maintenance of board certifications.

DEA license—Federal controlled substance registration issued by the U.S. Drug Enforcement Administration allowing health care practitioners to prescribe and dispense controlled substances. Eligible applicants include physicians, dentists, nurse practitioners, physician assistants, nurse anesthetists, and clinical nurse specialists. If license lists "Fee Exempt," the DEA license may only be used at the location listed. If "Fee Paid," the DEA can be utilized at multiple locations within the state listed on the license. Address can be changed if provider needs to work and prescribe/dispense in a different state. A health care provider may hold multiple DEA licenses.

Degree or diploma—Document confirming the title or degree conferred to a provider upon graduation of a medical school or program.

Delineation of privileges—A comprehensive list of all procedures or encounter types a practitioner is allowed to perform or treat while providing coverage at a facility. Typically varies by specialty; the practitioner selects the privileges desired, and the facility approves them during or upon conclusion of the privileged process.

Disclosure questions—Set of attestation questions (usually yes/no) that requests details around a provider's background, licensure actions, disciplinary actions from post-graduate training forward, and/or criminal or personal drug use.

Education Council for Foreign Medical Graduates (ECFMG)—Certification process for international medical graduates (IMGs) that assesses whether they are ready to train in U.S. graduate medical education programs, where they provide supervised patient care. ECFMG certification is a rigorous process, evaluating medical knowledge using the same examinations taken by U.S. medical school graduates. IMGs also must demonstrate appropriate clinical and communication skills. Additionally, ECFMG verifies the authenticity of their medical education credentials directly with their medical schools. ECFMG certification is required for IMGs who wish to enter a U.S. program of GME accredited by the Accreditation Council for Graduate Medical Education (ACGME), apply for Step 3 of the United States Medical Licensing Examination (USMLE), or obtain an unrestricted license to practice medicine in the U.S.

Fellowship—Higher education program for physicians that typically occurs post-residency to obtain additional and specialized training in a field.

Fingerprinting—Required for some background screens (state-specific) and some licensing boards. Process can involve ink print cards or LiveScan (electronic) prints, and requirements and processing times vary widely depending on the requesting entity and state.

Licensure—Can be state (state license or CSR) or federal (DEA). Managed by different boards, depending on provider type and specialty. Length to obtain, requirements, and length between renewal all vary, again depending on provider type, state, and specialty.

National Practitioner Data Bank (NPDB)—A web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners and suppliers. Established by Congress in 1986, it is a workforce tool that prevents practitioners from moving from one state to another state without disclosure or discovery of previous damaging performance. Only eligible entities can pull copies on behalf of a practitioner, but a practitioner can request a self-query at any time.

Neonatal Resuscitation Program (NRP)—Training and certification for health care professionals who care for newborns at the time of delivery. Typically good for two years after obtaining.

Pediatric Advanced Life Support (PALS)—Training and certification program geared towards health care providers who respond to emergencies in infants and children and for personnel in emergency response, emergency medicine, intensive care, and critical care units. Many online-only options are available, though some facilities require a course through the American Red Cross or the American Heart Association that includes a combination of classroom or online instruction and in-person skills assessments. Typically good for two years after obtaining.

Peer reference—Verification typically required and obtained during the credentialing process that gathers and documents confidential feedback from a provider's clinical peer. Standards can vary but often require that the peer be of an equivalent or higher educational background and have had recent (within two years) clinical contact with the provider being evaluated and be able to attest to the provider's clinical competency.

Primary source verification (PSV)—The act of obtaining a verification directly from the providing source. For example, a PSV peer reference goes directly from the peer providing the reference back to the requesting entity. Most state license verification sites are deemed PSV sources of data.

Residency—The training program and resulting certificate confirming completion by a physician of a post-graduate course of training. Most commonly three-year programs, where the first year (PGY I) may also be called an internship. Providers often have an active medical license during their final year (PGY III) and typically are eligible to sit for board exams after completing their final year. Residencies provide years of supervised training where practitioners can have patient contact and develop critical skills and communication techniques in a teaching and learning environment, led by tenured, licensed physicians.

U.S. Department of Transportation (DOT)—Most commonly refers to a medical certification provided by a certified health care professional and obtained by commercial drivers demonstrating physical, mental, and emotional fitness to perform in a commercial driving role.

Additional information about credentialing can be found at: namss.org

Section 2: Occupational Health Screening Requirements

Chain of custody—An official document that creates a paper/electronic trail of everyone who's handled a particular specimen. Most commonly seen in reference to urinalysis screenings.

Chest X-ray—Commonly used to rule out active Tuberculosis (TB) infections in individuals who have tested positive in the past for TB via a TB skin test (TST). Individuals who have received a Bacille Calmette-Guérin (BCG) vaccination, most often received outside the U.S., may present with antibodies for TB (and therefore receive a positive test result), and the chest X-ray provides suitable evidence an individual is tuberculosis-free. Some facilities may request a chest X-ray in providers with a history of positive skin tests. In 2019, the CDC updated its recommendations to state that "Health care personnel with a prior positive TB test and documented normal chest radiograph do not require a repeat radiograph unless they are symptomatic."

Color Blind test—A visual exam to rule out color blindness; Ishihara color plate test is commonly utilized.

Covid-19 vaccine—This can be a single vaccination or a series, depending on the vaccine manufacturer. Often required by health care facilities; proof of a recent booster shot may also be requested. Acceptance of declination forms varies depending on state and facility.

Hepatitis B (Hep B) immunity—Can be demonstrated by acceptable vaccination records, a surface antibody test, or a positive titer result. If immunity is not verifiable via titer or surface test, a series of two or three vaccinations must be restarted (two doses of Heplisav-B or a three-dose series of either Engerix-B or Recombivax HB), and proof of number of doses and date of last vaccination should be requested. Many facilities will accept a declination form for Hep B status during credentialing.

Immunization (or vaccination)—The process by which an individual becomes protected against (immune from) a specific disease by stimulating the body's immune response. Often used interchangeably with vaccination and/or inoculation.

Influenza (Flu)—An acute respiratory illness caused primarily by one of two influenza viruses—Influenza A or B. Influenza epidemics typically occur during late fall through early spring, and most cases are due to Influenza A infection. Immunization against flu is commonly required by health care facilities to be received annually during "flu season," which is often defined as September through April.

Mask fit test—Carried out on individuals who may be exposed to inhalation of toxic substances while performing their job. Test assesses the proficiency and "fit" of a respirator's (mask's) seal between the mask and the individual's face and measures the amount of leakage the seal permits. Often called a fit test or respirator fit test.

Measles, Mumps, Rubella (MMR) vaccine—Immunity to MMR can be demonstrated by acceptable vaccination records or a positive titer result. If neither are available, a two-dose series can be started. Second dose is given four weeks after the first dose, and proof of number of doses and date of last vaccination should be requested.

Monkeypox/Smallpox vaccine—Can help protect against smallpox, monkeypox, and other diseases caused by orthopoxviruses, including Vaccinia virus. Usually administered as a series of two injections, four weeks apart. People who have received smallpox vaccine in the past might only need one dose. Booster doses are recommended every two or 10 years if a person remains at continued risk for exposure to smallpox, monkeypox, or other orthopoxviruses.

Physical exam or statement of health (SOH)— Physical exams are often required during the credentialing or onboarding process and consist of a series of questions about overall health, restrictions, and medications; they are used to identify whether the subject is fit for the upcoming job. A statement of health form is sometimes required in lieu of or in addition to a physical exam and attests to a candidate's fitness for the upcoming job. Both forms should be signed by a qualified health care practitioner.

Purified protein derivative (PPD)—The solution used to administer a TB skin test (TST); also called tuberculin.

QuantiFERON-TB Gold (QFT) blood test—Used to test for Tuberculosis (TB) infection. Positive result indicates a possible infection and typically requires a chest X-ray be performed to rule this out. Preferred TB testing method of the CDC.

T-Spot blood test—Used to test for Tuberculosis (TB) infection. Positive result indicates a possible infection and typically requires a chest X-ray be performed to rule this out.

TB Skin Test (TST)—Used to test for Tuberculosis (TB) infection. Positive result (noted by the size of the induration on the skin) indicates a possible infection and typically requires a chest X-ray be performed to rule this out. Bacille Calmette-Guérin vaccinations as a child may lead to a positive result, even in the absence of infection. In a TST, a small amount of PPD is injected under the top layer of skin. Injected individual must return within the window of 48 and 72 hours for a medical professional to check the area and indicate the size (in mm) of any resulting induration. Most commonly an induration can be no larger than 5mm to be considered a negative result. The terms Mantoux, TB skin test, and PPD are often used interchangeably.

Tetanus, Diphtheria, Pertussis (TDAP) vaccine— Typically received as a childhood vaccination; CDC recommends adults receive a booster dose every 10 years.

Titer—A blood draw that measures the concentration of antibodies. Used to demonstrate immunity, most often for MMR, Varicella, and Hep B. If, upon testing, sufficient levels of antibodies don't exist to reach established thresholds, a vaccination series can provide the boost needed to reach appropriate levels. A positive titer result is the desired outcome (positive for the presence of sufficient antibodies).

Tuberculosis (TB)—A potentially serious bacterial infection that affects the lungs. Can be ruled out through skin test (PPD or TST), blood test (T-Spot or QFT), or clear chest X-ray.

U.S. Centers for Disease Control and Prevention (CDC)—Federal agency that conducts and supports health promotion, prevention, and preparedness against disease in the U.S., established in 1946.

Urinalysis (UA)—Also referred to as drug screen or panel, this screen tests for the presence of a

variety of drugs, depending on the panel ordered. A 10-panel is commonly required, which tests for the presence of cocaine, marijuana, PCP, amphetamines, opiates, benzodiazepines, barbiturates, methadone, propoxyphene, and Quaaludes. Additional drugs can be added to panels, such as MDA, nicotine, alcohol, or extended opiates or painkillers such as oxycodone.

Vaccination (or immunization)—The process by which an individual becomes protected against (immune from) a specific disease by stimulating the body's immune response. Often used interchangeably with vaccination and/or inoculation.

Varicella Zoster (chickenpox)—An infectious disease causing a mild fever and a rash of itchy inflamed blisters. Childhood vaccinations are now commonly given; immunity to Varicella can be demonstrated by acceptable vaccination records or a positive titer result. If neither are available, an individual who has never received a dose should start a two-dose series. Second dose is given four weeks after the first dose, and proof of number of doses and date of last vaccination should be requested. If an individual has received one dose, a booster shot will typically suffice (with acceptable proof of vaccination).

Section 3: Payor (Insurance) Enrollment Terms

Clearinghouse—Connected to the billing system and responsible for sending the claims to insurance companies. Examples are Navicure, Gateway, Emdeon, Availity.

Council of Affordable Quality Healthcare (CAQH)—Online repository often used by payers (insurance companies) during the credentialing and recredentialing process. Each provider is issued a CAQH ID number along with a username and password. It's important to keep this information securely stored as providers need to attest their information every 90 days. Some health care facilities utilize provider CAQH profiles to populate credentialing applications for education, work history, affiliations, and malpractice insurance details—yet another reason providers should keep their profiles complete and attested to.

Current Procedural Terminology (CPT) codes—Uniform language for coding medical services and procedures to streamline the reporting and billing process. This medical code set is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies, and accreditation organizations. CPT codes are used in conjunction with ICD-9 or ICD-10 codes during the electronic medical billing process. These codes, when reported from a health care facility, can also provide an overview of provider's clinical and procedural volume and are often requested for the previous 24 months (as case logs or procedure logs) during the credentialing process.

Delegated credentialing—When groups are large enough (such as hospitals or universities), payers can grant an addendum to a contract allowing groups to maintain their own credentialing. With delegated credentialing, the group or its contracted company are responsible for completing the primary source verification process typically performed by the insurance company. It's the responsibility of the delegated entity to ensure that all providers meet the standards as set forth by the insurance company. Once the provider is credentialed at the facility (such as a hospital) the entity would send each delegated payor a roster (typically once a month) showing all employed providers and any new additions since the last report.

Electronic data interchange (EDI)—Communication channel by which a billing system communicates claim data to the various payers.

Electronic funds transfer (EFT)—Electronic funds transfer is the preferred method of payment for many insurance companies and the required form of payment for Medicare. Medicare requires providers to complete form CMS-588 when enrolling in Medicare, which details payment preferences.

Electronic remittance advice (ERA)—Digital explanation of benefits (EOB) that shows what the insurance company paid (or didn't pay) and all the claim details. Many billing systems can automatically post these ERAs to the patient's account.

Federal (government) payers—Medicare, Medicaid, and Tricare. A provider most commonly becomes credentialed through Medicare, then Medicaid, then private payers or Tricare as applicable. Medicare is administered on a federal level and Medicaid on a state-

by-state level. Tricare is the health care program for uniformed service members, retirees, and their families and is managed by the Defense Health Agency.

Group NPI (Type II)—A national provider identifier (NPI) for a facility with a tax ID number or for locations under a facility with a tax ID number. Facilities with multiple offices will have one Type II NPI that serves as the primary billing NPI and additional NPIs for each location. Each provider is linked to the tax ID and the Type II NPI during the credentialing process. Type II NPIs are under 32a and 33a on a standard 1500 claim form. Facilities must apply for a Type II NPI after they have a tax ID number and/or location.

ICD-9 codes—Set of medical codes intended for the classification of diseases or diagnoses. (From the International Classification of Diseases, Ninth Revision, Clinical Modification, which was widely used until the 10th Revision was released in 1999.)

ICD-10 codes—Current system used by physicians and other health care providers to classify and code all diagnoses, symptoms, and procedures recorded in conjunction with hospital care in the U.S. (From the International Classification of Diseases, 10th Revision, Clinical Modification.)

Individual NPI (Type I)—A national provider identifier (NPI) intended for health care providers who are individuals, including physicians, psychiatrists, and all sole practitioners. An individual is eligible for only one NPI.

Medicaid—An assistance program for low-income patients' medical expenses, managed on a statewide level. Enrollment in Medicare must be initiated and approved before enrollment in Medicaid can be approved.

Medicare—Medical insurance program for people over 65 and for younger disabled people and dialysis patients. Practitioners who want to treat patients with Medicare must meet their credentialing standards and go through the enrollment application process. This is typically the first payer enrollment a provider goes through, and it takes an average of 45 days to complete. Medicare allows for retroactive billing for approved providers for all services performed during the waiting period, up to 60 days. General steps for enrollment as a provider in Medicare are: Obtain an NPI; complete Medicare enrollment application CMS 855-I through the Provider Enrollment, Chain, and Ownership System (PECOS); select a specialty; and provide requested supporting documents. Benefits can be reassigned to other facilities by completion of a CMS 855-R through PECOS.

National Provider Identifier (NPI)—Unique identification number for covered health care practitioners, created to help send health information electronically more quickly and effectively. Covered health care providers, all health plans, and health care clearinghouses must use NPIs in their administrative and financial transactions. Look up and verify numbers at npiregistry.cms.hhs.gov.

Payer or payor—Typically refers to an insurance company; can be a government program such as Medicare or Medicaid or private. Provides reimbursement for covered practitioners performing covered procedures or services for patients holding insurance through the respective payer.

Private payer—Any private insurer such as Aetna, BCBS, Cigna, United, etc. Enrollment typically takes between 90 and 120 days and may require Medicare enrollment to be complete first.

Provider enrollment—The process by which a health care practitioner becomes credentialed with an insurance payer to join the network and be eligible to submit billing requests on behalf of patients holding insurance through the respective payer.
Provider Enrollment, Chain, and Ownership System (PECOS)—Online Medicare provider enrollment system that allows providers to enroll in Medicare, update enrollment information, and reassign privileges to an organization.

Retroactive billing—Option with certain payers to bill for services performed during the waiting period for an application to be approved. Most commonly seen in Medicare and some states' Medicaid enrollment processes, retroactive billing allows the provider to hold the claims and submit to the insurance company once everything is approved, most often for a period not to exceed 60 days.

TRICARE—Health care coverage for and managed by the Military Health System. Also a sanction database that is a federated system of uniformed, civilian, and contract personnel and additional civilian partners at all levels of the U.S. Department of Defense.

U.S. Centers for Medicare and Medicaid Services (CMS)—Federal agency that provides health coverage to more than 100 million people through Medicare, Medicaid, the Children's Health Insurance Program, and the health insurance marketplace.

Section 4: Professional Councils, Government Agencies, and Associations

Accreditation Council for Graduate Medical Education (ACGME)—Independent, 501(c)(3), nonprofit organization that sets and monitors voluntary professional educational standards essential in preparing physicians to deliver safe, high-quality medical care to all Americans. Graduate medical education (GME) refers to the period of education in a particular specialty (residency) or subspecialty (fellowship) following medical school; the ACGME oversees the accreditation of residency and fellowship programs in the U.S.

American Medical Association (AMA)—Founded in 1847, the national association that convenes more than 190 state and specialty medical societies and other critical stakeholders. The AMA's mission is to promote the art and science of medicine and the betterment of public health.

AMA Physician Profile (a.k.a. initial profile)— provides comprehensive physician information, including education, training, board certifications, state license data, and more. Initial profiles are often used by a health care organization to confirm physician-submitted information when applying for clinical privileges at that organization. It is also used by payers to validate physician information for reimbursement and/or provider enrollment.

Board of trustees (BOT)—Often the final group in a hospital's administration that approves or denies application from physicians or health care practitioners requesting privileges at the hospital. Typically hospital privilege requests require a complete credentialing file containing verification of background, licensure, work history, and peer references. The file is reviewed by the hospital credentialing committee, then by the medical executive committee (MEC), and finally by the board of trustees. On occasion, a provider approved by the credentialing committee and/or MEC can be granted temporary privileges while waiting for the BOT to grant final, full approval of the requested privileges.

Education Council for Foreign Medical Graduates (ECFMG)—Granting body for the certification program that verifies the authenticity of international medical graduates' medical education credentials directly with their medical schools and evaluates medical knowledge using the same exams by U.S. medical school graduates.

Federation of State Medical Boards (FSMB)— Organization that represents the state medical and osteopathic regulatory boards—commonly referred to as state medical boards—within the U.S. and its territories. It supports its member boards as they fulfill their mandate of protecting the public's health, safety, and welfare through the proper licensing, disciplining, and regulation of physicians and, in most jurisdictions, other health care professionals.

Joint Commission—Organization that promotes patient safety and higher standard of quality and care by evaluating health care organizations; it has accredited and certified more than 22,000 health care organizations and programs in the U.S.

Medical executive committee (MEC)—Often the second authority group evaluating a provider's request for privileges at a hospital. Typically, hospital privilege requests require a complete credentialing file containing verification of background, licensure, work history, and peer references. The file is reviewed by the hospital credentialing committee, then by the medical executive committee, and finally by the board of trustees. On occasion, a provider approved by the credentialing committee and/or MEC can be granted temporary privileges while waiting for the BOT to grant final, full approval of the requested privileges.

Medical Staff Office (MS)—Office and associated staff within a hospital or health system managing provider credentialing, onboarding, and maintenance of compliance standards throughout a practitioner's affiliation with the hospital.

National Plan and Provider Enumeration System (NPPES)—System designed and implemented by the U.S. Centers for Medicare and Medicaid Services (CMS) to assign NPI numbers.

Office of Inspector General (OIG)—Largest inspector general's office in the federal government; has the authority to exclude individuals from federally funded health care programs for a variety of reasons, including a conviction for Medicare or Medicaid fraud.

SAM (System for Award Management)—Exclusion list database that identifies parties excluded from receiving federal contracts, certain subcontracts, and certain types of federal financial and nonfinancial assistance and benefits. Exclusions are also referred to as suspensions and debarments.

U.S. Drug Enforcement Administration (DEA)—Federal organization in charge of enforcing the controlled substances laws of the United States. Also responsible for granting DEA licenses to physicians and other eligible health care providers in order to prescribe or dispense controlled substances.

U.S. Occupational Safety and Health Administration (OSHA)—Federal agency that ensures safe and healthful working conditions for workers by setting and enforcing standards and by providing training, outreach, education, and assistance.

Appendix: Alphabetical List of all Terms

ACGME (Accreditation Council for Graduate Medical Education)—Independent, 501(c)(3), not-for-profit organization that sets and monitors voluntary professional educational standards essential in preparing physicians to deliver safe, high-quality medical care to all Americans. Graduate medical education (GME) refers to the period of education in a particular specialty (residency) or subspecialty (fellowship) following medical school; the ACGME oversees the accreditation of residency and fellowship programs in the US.

ACLS (Advanced Cardiovascular Life Support)—Certification attesting to a provider's training and competence utilizing a group of procedures and techniques that can treat life-threatening conditions, including cardiac arrest. Some versions are available as online-only courses, but many facilities require a course through American Red Cross (ARC) or the American Heart Association (AHA) that includes a combination of classroom/online instruction and in person skills assessments. Typically good for two years after obtaining.

AMA (American Medical Association)—Founded in 1847, the American Medical Association (AMA) is the largest and only national association that convenes 190+ state and specialty medical societies and other critical stakeholders. Throughout history, the AMA has always followed its mission: to promote the art and science of medicine and the betterment of public health. An AMA Physician Profile (aka initial profile) provides comprehensive physician information, including education, training, board certifications, state license data and more. Initial profiles are often used by a health care organization to confirm physician—submitted information when applying for clinical privileges at that organization. It is also used by Payors to validate physician information for reimbursement and/or provider enrollment.

Application—Any document used to gather information such as demographics, work history, affiliations, education, malpractice, background and/or peer reference information. May include state-specific applications, facility applications or agency onboarding applications.

ATLS (Advanced Trauma Life Support)—Training and certification program for medical providers responding to acute trauma cases, originally developed by the American College of Surgeons.

BLS (Basic Life Support)—Training and certification for care that first-responders, healthcare providers, and public safety professionals provide to anyone who is experiencing cardiac arrest, respiratory distress, or an obstructed airway. Many online-only options are available, though some facilities require a course through American Red Cross (ARC) or the American **Heart Association (AHA)** that includes a combination of classroom/online instruction and in person skills assessments. Typically good for two years after obtaining.

Board Certification—Refers to any number of professional board exams taken by various provider types and specialties to demonstrate proficiency in

a specialized field of medical expertise. Commonly recognized board certifications come from ABMS and AOA (for MD/DO), ANCC or AANP for Nurse Practitioners, NCCPA for Physician Assistants, ABDS for dentists, and many more. Many facilities may not recognize all board certifications available to practitioners so it's important to confirm what board certifications are expected and accepted by healthcare clients and facilities.

BOT (Board of Trustees)—Often the final group in a hospital's administration that approves or denies application from physicians or healthcare practitioners requesting privileges at the respective hospital. Typically hospital privilege requests require a complete credentialing file containing verification of background, licensure, work history and peer references. The file is reviewed by the hospital credentialing committee, then Medical Executive Committee, and finally by the Board of Trustees. On occasion, a provider approved by the Credentialing Committee and/or MEC can be granted temporary privileges while waiting for the BOT to grant final, full approval of the requested privileges.

CAQH—Council of Affordable Quality Healthcare. Online repository often used by Payors (insurance companies) during the credentialing and recredentialing process. Each provider is issued a CAQH ID number along with a username and password. It's important to keep this information securely stored as providers need to attest their information every 90 days. Some healthcare facilities utilize a provider's CAQH profiles to populate credentialing applications for education, work history, affiliations, and malpractice insurance details, yet another reason providers should keep their profiles complete and attested to.

Case logs—Also referred to as procedure logs, patient contact volume reports, CPT or ICD-10 codes, etc. Used to support clinical competency by demonstrating how often a provider performs a procedure, documents a diagnosis, or bills for a particular patient encounter type. Often required during the hospital privileging process.

Centers for Disease Control and Prevention (CDC)—Federal agency that conducts and supports health promotion, prevention, and preparedness against disease in the United States, established in 1946.

Certificate of Insurance (COI)—Provides record of current or previous malpractice coverage for a specific provider during a specific policy range (often one year) and indicates the policy number, carrier detail and malpractice limits for each line of coverage shown.

Chain of custody—An official document that creates a paper trail of everyone who's handled a particular specimen. Most commonly seen in reference to urinalysis screenings. Can be paper or electronic.

Chest X-ray—Commonly used to rule out active Tuberculosis (TB) infections in individuals that have tested positive in the past for TB via a TST (TB skin test). Individuals that have received a Bacille Calmette-Guérin (BCG) vaccination, most often received outside of the US, may present with antibodies for TB (and therefore receive a positive test result) and the chest x-ray provides suitable evidence an individual is tuberculosis-free. Some facilities may request a chest x-ray in providers with a history of positive skin tests. In 2019, the CDC updated their recommendations and state that "Health care personnel with a prior positive TB test and documented normal chest radiograph do not require a repeat radiograph unless they are symptomatic."

Claims History/Loss Run report—A letter or report provided by a malpractice insurance carrier that provides feedback around any or all claims filed on a policy while a specific provider was covered.

Clearinghouse—Connected to the billing system and is responsible for sending the claims to the insurance companies. Examples are Navicure, Gateway, Emdeon, Availity, etc.

CME (Continuing Medical Education)—Credits for physicians and other licensed healthcare practitioners; used to demonstrate continued or increased proficiency during credentialing, licensing, or certifications processes. Often required during renewal of licensure or for maintenance of board certifications.

CMS (Centers for Medicare and Medicaid Services)—The CMS provides health coverage to more than 100 million people through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace.

Color Blind test—A visual exam to rule out color-blindness; Ishihara color plate test is commonly utilized.

CEU (Continuing Education Unit)—A unit of credit for educational offerings given to professional persons, determined by a professional organization according to a mathematical formula after a thorough review of the program of study, the qualifications of the instructors, and the program objectives. Often utilized for maintaining quality, knowledge, competence and even credentialing requirements.

COVID-19—This can be a single vaccination or a series, depending on the vaccine manufacturer. Often required by healthcare facilities, proof of a recent booster shot may also be requested. Acceptance of declination forms varies depending on state and facility.

Current Procedural Terminology (CPT codes)—Uniform language for coding medical services and procedures to streamline the reporting and billing process. This medical code set is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations. CPT codes are used in conjunction with ICD-9 or ICD-10 codes during the electronic medical billing process. These codes, when reported from a healthcare facility, can also provide an overview of provider's clinical and procedural volume and are often requested for the previous 24 months (as case logs or procedure logs) during the credentialing process.

DEA (Drug Enforcement Administration)—Federal organization in charge of enforcing the controlled substances laws of the United States. Also responsible for granting DEA licenses to physicians and other eligible healthcare providers in order to prescribe or dispense controlled substances.

DEA (license)—Federal controlled substance registration allowing healthcare practitioners to prescribe and dispense controlled substances. Eligible applicants include physicians, dentists, nurse practitioners, physician assistants, nurse anesthetists, and clinical nurse specialists. If license lists "Fee Exempt," the DEA license may only be used at the location listed. If "Fee Paid," the DEA can be utilized at multiple locations within the state listed on the license. Address can be changed if provider needs to work and prescribe/dispense in a different state. A healthcare provider may hold multiple DEA licenses.

Delegated Credentialing—When groups are large enough (such as hospitals or universities) the payors can grant an addendum to a contract allowing the group to maintain their own credentialing. With delegated credentialing, the group or its contracted company are responsible for completing the primary source verification process typically performed by the insurance company. It's the responsibility of the delegated entity to ensure that all providers meet the standards as set forth by the insurance company. Once the provider is credentialed at the facility (such as a hospital) the entity would send each delegated Payor a roster (typically once a month) showing all employed providers and any new additions since the last report.

Delineation of Privileges—A comprehensive list of all procedures or encounter types a practitioner is allowed to perform or treat while providing coverage at a facility. Typically varies by specialty; the practitioner selects the privileges they desire, and the facility approves them during or upon conclusion of the privileging process.

Diploma/Degree—Document confirming the title or degree conferred to a provider upon graduation of a medical school or program.

Disclosure Questions—Set of attestation questions (usually yes/no) that request details around a provider's background, licensure actions, disciplinary actions from post-graduate training forward, and/or criminal or personal drug use.

DOT (Department of Transportation)—Most commonly refers to a medical certification provided by a certified healthcare professional and obtained by commercial drivers demonstrating physical, mental, and emotional fitness to perform in a commercial driving role.

ECFMG (Education Council for Foreign Medical Graduates)—Certification process for International Medical Graduates (IMGs) that assesses whether they are ready to train in US GME (Graduate Medical Education) programs, where they provide supervised patient care. ECFMG Certification is a rigorous process, evaluating medical knowledge using the same examinations taken by U.S. medical school graduates. IMGs also must demonstrate appropriate clinical and communication skills. Additionally, ECFMG verifies the authenticity of their medical education credentials directly with their medical schools. ECFMG Certification is required for IMGs who wish to: 1) Enter a U.S. program of GME accredited by the Accreditation Council for Graduate Medical Education (ACGME) 2) Apply for Step 3 of the United States Medical Licensing Examination® (USMLE®) 3) Obtain an unrestricted license to practice medicine in the United States.

ECFMG (Education Council for Foreign Medical Graduates)—Granting body for the ECFMG certification program that verifies the authenticity of international medical graduates' medical education credentials directly with their medical schools and evaluates medical knowledge using the same exams by US medical school graduates.

EDI—Electronic data interchange. Communication channel by which your billing system communicates claim data to the various Payors.

EFT—Electronic funds transfer is the preferred method of payment for many insurance companies and the required form of payment for Medicare. Medicare requires you to complete form CMS-588 when enrolling in Medicare which details payment preferences.

Electronic Remittance Advice (ERA)—Electronic remittance advice is a digital EOB (explanation of benefits) that shows what the insurance company paid (or didn't pay) and all the claim details. Many billing systems can automatically post these ERAs to the patient's account.

Federal (Gov't) Payors—Medicare, Medicaid, TRICARE. A provider most commonly becomes credentialed through Medicare, then Medicaid, then private Payors or TRICARE as applicable. Medicare is administered on a federal level and Medicaid on a state-by-state level. TRICARE is the health care program for uniformed service members, retirees, and their families and is managed by the Defense Health Agency.

Fellowship—Higher education program for physicians that typically occurs post-residency to obtain additional and specialized training in a field.

Fingerprinting—Required for some background screens (state-specific) and some licensing boards. Process can involve ink print cards or LiveScan (electronic) prints and requirements and processing times vary widely depending on the requesting entity and state.

FSMB—The Federation of State Medical Boards represents the state medical and osteopathic regulatory boards—commonly referred to as state medical boards—within the United States, its territories, and the District of Columbia. It supports its member boards as they fulfill their mandate of protecting the public's health, safety and welfare through the proper licensing, disciplining, and regulation of physicians and, in most jurisdictions, other health care professionals.

Group NPI (Type II)—Referred to as an organizational NPI or Type II NPI. Type I NPI is for the individual while Type II is for a facility Tax ID or for locations under a facility tax ID. If you have multiple offices, you'll have one.

Hepatitis B (Hep B)—Immunity to Hep B can be demonstrated by acceptable vaccination records, a surface antibody test or a positive titer result. If immunity is not verifiable via titer or surface test, a series of two or three vaccinations must be restarted (2-doses of Heplisav-B or a 3-dose series).

ICD-9 codes—Set of medical codes intended for the classification of diseases or diagnoses. (International Classification of Diseases, 9th Revision, Clinical Modification, widely used until the 10th Revision was released in 1999.)

ICD-10 codes—Current system used by physicians and other healthcare providers to classify and code all diagnoses, symptoms and procedures recorded in conjunction with hospital care in the United States. (International Classification of Diseases, 10th Revision, Clinical Modification.)

Immunization (see vaccination)—The process by which an individual becomes protected against (immune from) a specific disease by stimulating the body's immune response. Term is often used interchangeably with vaccination and/or inoculation.

Individual NPI (Type I)—Intended for healthcare providers who are individuals, including physicians, psychiatrists, and all sole practitioners. An individual is eligible for only one NPI.

Influenza (Flu)—Flu is an acute respiratory illness caused primarily by one of two influenza viruses — Influenza A or B. Influenza epidemics typically occur during late fall through early spring, and most cases are

due to Influenza A infection. Immunization against flu is commonly required by healthcare facilities to be received annually during "flu season" which is often defined as September through April.

Joint Commission—Established in 1951, Joint Commission values and promotes patient safety and higher standard of quality and care and has accredited and certified over 22,000 healthcare organizations and programs in the United States.

Licensure—Can be state (state license or CSR) or federal (DEA). Managed by different boards, depending on provider type and specialty. Length to obtain, requirements, and length between renewal all vary, again depending on provider type, state and specialty.

Mask fit test—Carried out on individuals who may be exposed to inhalation of toxic substances while performing their job. Test assesses the proficiency and "fit" of a respirator (mask's) seal between the mask and the individual's face and measures the amount of leakage the seal permits. Often called a fit test or Respirator fit test.

MEC (Medical Executive Committee)—Often the second authority group evaluating a provider's request for privileges at a hospital. Typically, hospital privilege requests require a complete credentialing file containing verification of background, licensure, work history and peer references. The file is reviewed by the hospital credentialing committee, then Medical Executive Committee, and finally by the Board of Trustees. On occasion, a provider approved by the Credentialing Committee and/or MEC can be granted temporary privileges while waiting for the BOT to grant final, full approval of the requested privileges.

Medicaid—An assistance program for low-income patients' medical expenses, managed on a statewide level. Enrollment in Medicare must be initiated and approved before enrollment in Medicaid can be approved.

Medicare—Medicare is a medical insurance program for people over 65 and younger disabled people and dialysis patients. If a practitioner wants to treat patients with Medicare, they must meet Medicare credentialing standards and go through the enrollment application process. This is typically the first Payor/payor enrollment a provider goes through and takes an average of 45 days to complete. Medicare allows for retroactive billing for approved providers for all services performed during the waiting period, up to 60 days. General steps for enrollment as a provider in Medicare are: 1) Obtain an NPI, 2) complete Medicare enrollment application CMS 855-I through the Provider Enrollment, Chain and Ownership System (PECOS), 3) select a specialty, and 4) provide requested supporting documents. Benefits can be reassigned to other facilities through completion of a CMS 855-R through PECOS.

MMR (Measles, Mumps, Rubella)—Immunity to MMR can be demonstrated by acceptable vaccination records or a positive titer result. If neither are available, a two-dose series can be started. Second dose is given four weeks after the first dose, and proof of number of doses and date of last vaccination should be requested.

Monkeypox/Smallpox vaccine—Can help protect against smallpox, monkeypox, and other diseases caused by orthopoxviruses, including vaccinia virus. Usually administered as a series of 2 injections, 4 weeks apart. People who have received smallpox vaccine in the past might only need 1 dose. Booster doses are recommended every 2 or 10 years if a person remains at

continued risk for exposure to smallpox, monkeypox, or other orthopoxviruses.

MSO (Medical Staff Office)—Office and associated staff within a hospital or health system managing provider credentialing, onboarding, and maintenance of compliance standards throughout a practitioner's affiliation with the hospital.

National Practitioner Data Bank (NPDB)—A web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners and suppliers. Established by Congress in 1986, it is a workforce tool that prevents practitioners from moving state to state.

NPI (National Provider Identifier)—Unique identification number for covered health care practitioners, created to help send health information electronically more quickly and effectively. Covered health care providers, all health plans and health care clearinghouses must use NPIs in their administrative and financial transactions. Look up and verify numbers at npiregistry.cms.hhs.gov.

NPPES (National Plan and Provider Enumeration System)—System designed and implemented by the Centers for Medicare & Medicaid Services (CMS) to assign NPI numbers.

NRP (Neonatal Resuscitation Program)—Training and certification for healthcare professionals that care for newborns at the time of delivery. Typically, good for two years after obtaining of either Engerix-B or Recombivax HB) and proof of number of doses and date of last vaccination should be requested. Many facilities will accept a declination form for Hep B status during credentialing.

OIG (Office of Inspector General)—Largest inspector general's office in the Federal government that has the authority to exclude individuals from Federally funded health care programs for a variety of reasons, including a conviction for Medicare or Medicaid fraud.

OSHA (Occupational Safety and Health Administration)—Ensures safe and healthful working conditions for workers by setting and enforcing standards and by providing training, outreach, education, and assistance.

Payor—Typically refers to an insurance company, can be federal/gov't such as Medicare or Medicaid or a private Payor such as Cigna or United. Provides reimbursement for covered practitioners performing covered procedures or services for patients holding insurance through the respective Payor.

PALS (Pediatric Advanced Life Support)—Training and certification program geared towards healthcare providers who respond to emergencies in infants and children and for personnel in emergency response, emergency medicine, intensive care, and critical care units. Many online-only options are available, though some facilities require a course through American Red Cross (ARC) or the American Heart Association (AHA) that includes a combination of classroom/online instruction and in person skills assessments. Typically good for two years after obtaining.

Peer Reference—Verification typically required and obtained during the credentialing process that gathers and documents confidential feedback from a provider's clinical peer. Standards can vary, but often require that the peer be of an equivalent or higher educational background and have had recent (within 2 years) clinical

contact with the provider being evaluated and be able to attest to their clinical competency.

Physical Exam/Statement of Health (SOH)—Physical exams are often required during the credentialing/onboarding process and are comprised of a series of questions about overall health, restrictions, and medications and is used to identify whether the subject is fit for the upcoming job. A Statement of Health form is sometimes required in lieu of or in addition to a physical exam and attests to a candidate's fitness for the upcoming job. Both forms should be signed by a qualified health care practitioner.

Primary Source Verification (PSV)—The act of obtaining a verification directly from the providing source. For example, a PSV peer reference goes directly from the peer providing the reference back to the requesting entity. Most state license verification sites are deemed PSV sources of data.

Private Payors—Refers to any private Payor such as United, Aetna, Cigna, BCBS, etc. Enrollment is typically between 90–120-day process and may require Medicare enrollment to be complete first.

Provider Enrollment—The process by which a healthcare practitioner becomes credentialed with an insurance Payor(s) to join the network and be eligible to submit billing requests on behalf of patients holding insurance through the respective Payor(s).

Provider Enrollment, Chain and Ownership System (PECOS)—Online Medicare provider enrollment system allows you to enroll in Medicare, update enrollment information and reassign privileges to an organization.

Purified Protein Derivative (PPD)—Tuberculin (also called purified protein derivative or PPD) is the solution used to administer a TB skin test (see TST).

QuantiFERON-TB Gold (QFT) blood test—Used to test for Tuberculosis (TB) infection. Positive result indicates a possible infection and typically requires a chest x-ray be performed to rule this out. Preferred TB testing method of the CDC.

Residency—The training program and resulting certificate confirming completion by a physician of a post-graduate course of training. Most commonly three-year programs, where the first year (PGY I) may also be called an internship. Providers often have an active medical license during their final (PGY III) year and typically are eligible to sit for board exams after completing their final year. Residencies provide years of supervised training where practitioners can have patient contact and develop critical skills and communication.

Retroactive Billing—Option with certain Payors to bill for services performed during the waiting period for an application to be approved. Most commonly seen in Medicare and some states' Medicaid enrollment processes, retroactive billing allows you to hold the claims and submit to the insurance company once everything is approved, most often for a period not to exceed 60 days.

SAM (System for Award Management)—Exclusion list database that identifies parties excluded from receiving Federal contracts, certain subcontracts, and certain types of Federal financial and non-financial assistance and benefits. Exclusions are also referred to as suspensions and debarments.

TB (Tuberculosis)—A potentially serious bacterial infection that affects the lungs. Can be ruled out through skin test (PPD or TST), blood test (T-Spot or QFT) or clear chest x-ray.

TDAP (Tetanus, Diphtheria, Pertussis)—Typically received as a childhood vaccination; CDC recommends adults receive a booster dose every 10 years.

Titers—A blood draw that measures the concentration of antibodies. Used to demonstrate immunity, most often for MMR, Varicella and Hep B. If upon testing, sufficient levels of antibodies don't exist to reach established thresholds, a vaccination series can provide the boost needed to reach appropriate levels. A positive titer result is the desired outcome (positive for the presence of sufficient antibodies).

TRICARE—Healthcare coverage for and managed by the Military Health System. Also a sanction database that is a federated system of uniformed, civilian and contract personnel and additional civilian partners at all levels of the Department of Defense.

T-Spot blood test—Used to test for Tuberculosis (TB) infection. Positive result indicates a possible infection and typically requires a chest x-ray be performed to rule this out.

TST (TB Skin Test)—Used to test for Tuberculosis (TB) infection. Positive result (noted by the size of the induration on the skin) indicates a possible infection and typically requires a chest x-ray be performed to rule this out. BCG vaccinations as a child may lead to a positive result, even in the absence of infection. In a TST, a small amount of PPD is injected under the top layer of skin. Injected individual must return within the window of 48 and 72 hours for a medical professional to check the area and indicate the size (in mm) of any resulting induration. Most commonly an induration can be no larger than 5mm to be considered a negative result. The terms Mantoux, TB skin test, and PPDs are often used interchangeably. Type II NPI that serves as your primary billing NPI and additional NPIs for each location. Each provider is linked to the Tax ID and the Type II NPI during the credentialing process. You can find Type II NPIs under 32a and 33a on a standard 1500 claim form. Your Type II NPI must be applied for once you have your Tax ID and/or location.

Urinalysis (UA)—Also referred to as drug screen/panel, this screen tests for the presence of a variety of drugs, depending on the panel ordered. A 10-panel is commonly required which tests for the presence of cocaine, marijuana, PCP, amphetamines, opiates, benzodiazepines, barbiturates, methadone, propoxyphene, & Quaaludes. Additional drugs can be added to panels such as MDA, nicotine, alcohol, or extended opiates or painkillers such as oxycodone.

Vaccinations (see Immunizations)—The process by which an individual becomes protected against (immune from) a specific disease by stimulating the body's immune response. Term is often used interchangeably with vaccination and/or inoculation.

Varicella Zoster (Chickenpox)—An infectious disease causing a mild fever and a rash of itchy inflamed blisters. Childhood vaccinations are now commonly given; immunity to Varicella can be demonstrated by acceptable vaccination records or a positive titer result. If neither are available, an individual that has never received a dose should start a two-dose series. Second dose is given 4 weeks after the first dose and proof of number of doses and date of last vaccination should be requested. If an individual has received one dose, a booster shot will typically suffice (with acceptable proof of vaccination).

Engage With ASA!

ASA CENTRAL | Health Care Section

CALENDAR & EVENTS *americanstaffing.net/events*

RESOURCES *americanstaffing.net/resources*

VOLUNTEER | Become an ASA Volunteer at *americanstaffing.net/volunteer*

The content in this resource was
produced exclusively by ASA volunteers.