I. STATEMENT OF PURPOSE
To ensure that the directives of the medical staff bylaws are carried out and that accreditation and regulatory requirements are consistently met.

II. STATEMENT OF POLICY
Written guidelines shall direct the processing of applications for medical staff reappointment and renewal of privileges. All appointments to the medical staff are for a period not to exceed two years. [Insert name of facility] uses privileging criteria, such as volume data and CME, to determine if the physician is qualified to reapply for privileges.

III. PROCEDURE
1. At least 90 days prior to the expiration of privileges, each member of the medical staff shall be provided with a reappointment application, a listing of current medical staff privileges, current staff category, and department assignment.
2. Medical staff members are expected to return the completed application form and all supplemental information to the Medical Staff Office within 30 days (60 days prior to the expiration of privileges). Practitioners failing to supply necessary information by that date risk delay in reappointment processing, which may result in a loss of membership and privileges.
3. The medical staff member is to submit the following documents to the medical staff services office:
   a. Completed reappointment application, including no less than the following information and/or other information as designated by the governing body:
      o Current licensure and past and pending challenges to licensure including voluntary and involuntary relinquishments;
      o DEA registration;
      o Past (two years) and pending malpractice history (including claims, suits, notices of intent, and settlements);
      o Past (two years) and pending challenges to medical staff membership/privileges at other healthcare facilities (including voluntary or involuntary relinquishment);
MSC Reappointment and Renewal of Privileges Policy – SAMPLE

- Professional liability coverage and policy limits (including denial of professional liability coverage and/or policy cancellation or nonrenewal);
- Healthcare-related employment/appointment history (including terminations, challenges or decisions pending, and voluntary/involuntary resignations and relinquishments) (generally two years);
- CME activity;
- Health status as related to ability to perform professional and medical staff duties, with verification by the department chairperson or chief of staff.

b. Completed delineation of privilege form with required documentation to support requests for new privileges.

c. A request for desired staff category and department assignment (if applicable)
d. Authorization for release of information form.
e. Clinical/quality data from external sources, if adequate data are not available through the facility.

4. The burden is on the applicant to submit the completed application within the recommended time frame. If all required information is not submitted with the application or items are missing, the applicant will be promptly notified. If the requested information is not submitted within 30 days, a certified letter will be mailed to the applicant advising that his/her medical staff privileges will be considered voluntarily resigned if he/she does not respond within the period specified by the facility’s bylaws.

5. The medical staff services office shall verify information provided by the applicant and obtain supplemental information as follows:

5.1. Primary source reverification of:
- Current and valid license, and past and pending challenges to licensure, including voluntary/involuntary relinquishment (verified in state of practice);
- DEA/state registration;
- Past (two years) and pending malpractice history (including claims, notices of intent, and settlements);
- Current professional liability coverage and policy limits (according to hospital policy);
- Past (two years) and pending challenges to medical staff membership/privileges at other healthcare facilities, including voluntary/involuntary relinquishments;
- Healthcare-related employment history, including terminations, challenges or decisions pending, and voluntary resignations and relinquishments (generally two years);
- OIG sanctions (review of OIG exclusions list, National Practitioner Data Bank (NPDB) or AMA Masterfile with Medicare/Medicaid sanctions);
- NPDB query;
- Specialty board status and/or recertification (if applicable);
• Criminal background check.

5.2 The verification will be obtained from such primary sources, but not limited to, NPDB, OIG/GSA, AMA Physician Masterfile, the local state police criminal justice information center, and reference company, if applicable.

NOTE: In addition, primary source verification of licensure will be conducted at the time of license expiration and if/when a change in privileges is requested.

6. The medical staff services professional shall notify the quality improvement department of the need to collect and assemble all pertinent ongoing professional practice and peer review data, medical staff meeting minutes, and other data relevant to the reappointment applicant. Time frames for requesting this internal data must be established to comply with the reappointment timeline.

7. The medical staff services professional shall compile all of the internal/external quality data (or other data as designated by the facility) when preparing the file for analysis, for example:
   • Ongoing professional practice evaluation and peer review data;
   • Past 24 months of clinical activity data;
   • Evidence of continuing medical education;
   • Department, general, and committee meeting attendance;
   • Medical record completion;
   • Participation in on-call schedules;
   • Utilization statistics;
   • Occurrence reports/complaints;
   • Reports of disciplinary action;
   • NPDB reports;
   • Patient satisfaction data;
   • Other data as required by the hospital.

8. References and/or evaluations should include all of the following:
   • Results of ongoing professional practice evaluation data, aggregated peer review data/activities, and volumes, to be utilized to provide practitioner-specific appraisal of competency and to determine renewal of clinical privileges compiled since last date of appointment;
   • Summary report of results of internal quality assurance monitoring;
   • Summary report of external quality assessment results, if applicable;
   • Written evaluation of competence by the department/division chairperson;
   • Current health status as it relates to the applicant's ability to perform clinical or professional duties;

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• Status of medical staff membership at other facilities with which the applicant is affiliated;
• Other as required by the hospital.

9. Reappointment information shall be collected and organized in the applicant's credentialing file. The most recent information should be on the top of each section.

10. An application shall be considered complete when the applicant has provided all necessary information, required supplemental information has been received, and verification and analysis are complete. When the reappointment application is complete, the credentialing file shall be forwarded to the department chairperson/chief of staff for his/her recommendations.

11. After the department chairperson/chief of staff reviews the credentialing file and makes his/her recommendations, the completed file is returned within the specified time frame to the medical staff services office. The [insert name of credentialing committee] shall review each completed application file, department reports, and all other relevant information at its next regularly scheduled meeting. If warranted, the [insert name of credentialing committee] will discuss with the appropriate department chairperson/chief of staff his/her recommendations concerning the requested privileges.

12. The [insert name of credentialing committee] shall make its recommendations regarding reappointment, staff category, department assignment, and clinical privileges, documenting those recommendations in committee meeting minutes.

13. Recommendations regarding clinical privileges, department assignment, staff category, and renewed membership shall be submitted to the Medical Staff Executive Committee (MEC) in the form of a report outlining all the relevant information available to it. The credentialing file will be available to the MEC upon request.

14. The MEC, at its next meeting, shall consider the recommendations of the [insert name of credentialing committee], document those recommendations in committee meeting minutes, and prepare its recommendations to the governing body.

15. When the recommendation of the MEC is adverse to the practitioner (reappointment or clinical privileges), the chief executive officer shall inform the applicant in writing via certified mail, outlining his/her right to due process as outlined by medical staff bylaws. Final action by the governing body shall be deferred until all hearings/proceedings have been afforded to or declined by the practitioner.

16. Favorable action by the governing body is considered its final decision.

17. The CEO shall notify the MEC and the department chair/chief of staff of the governing body’s decision. The applicant shall receive written notice of the governing body’s action. The governing body’s decision includes:
• Staff category;
• Department assignment;
• Clinical privileges;
• Any special conditions attached to the appointment.