Medical Staff Credentialing Files Policy – SAMPLE

Subject: Medical Staff Credentialing Files
Number:
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Approved by:
(Signature) Date
Distribution: Medical Staff, Credentialing Manual, Medical Staff Office

I. STATEMENT OF PURPOSE

1. To ensure that the policy directives of the medical staff bylaws are carried out and that accreditation and regulatory requirements are consistently met;
2. To designate the person responsible for creating, processing, and maintaining credentialing files;
3. To designate the person responsible for granting and monitoring access to credentialing files and releasing information therefrom.

II. STATEMENT OF POLICY

Written guidelines shall direct the creation, processing, and maintenance of the credentialing files of each medical staff applicant. Access to individual practitioner credentialing files and release of information contained in the credentialing files shall be limited to those individuals designated in this policy.

III. PROCEDURE

1. The medical staff service professional or other individual in the medical staff services office shall have the responsibility of obtaining all of the relevant documents required by the organization necessary for appointment/ reappointment to the medical staff. The assistance of the applicant may be necessary.
2. A separate record is maintained for each individual requesting medical staff membership or clinical privileges.
3. A typed, completed, and signed application shall be accepted by the medical staff services office by mail, in person, or electronically with a certified e-signature during regular business hours. The date of receipt shall be stamped on the application form.
4. Once the application is complete, a credentialing file is created to contain all correspondence and submitted material.
5. Information is verified as set forth in [*insert name of applicable policy*]. All requests and information received are date stamped. All responses and completed forms are placed in

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the credentialing file. The applicant has the final burden of producing, in writing, adequate information and resolving any doubts about the verified data.

6. Reappointment information shall be collected and organized in the practitioner's credentialing file. The most recent information should be placed at the top of each section.

All credentialing information shall be placed in the following order:

	Title	Material
6.1	Current Information	Reappointment Application (Current) Privilege Delineation Form (Current) NPDB Profile (Current) Malpractice History Update (Current)
6.2	Application	Original Application Original Privilege Delineation Form Curriculum Vitae Authorizations Malpractice History Form
6.3	Certificates	Insurance Specialty Boards ACLS/BCLS /ACTS/PALS DD214 ECFMG NPDB Profile CME Documentation Medical School/Residency Diplomas
6.4	Licenses	State Medical License State Controlled Substance License DEA Registration
6.5	Recommendations	Letters to request completion of clinical questionnaire Completed questionnaires and letters of recommendation
6.6	Correspondence	Letters to and from applicant Letters requesting verification of credentials

	Title	Material
		Information received regarding credentials and previous experience
6.7	Quality File	Maintain a separate file for protected professional peer review data on each physician. This file should contain reference letters, quality data (including FPPS and OPPE data), peer review activities, results of fair hearings, appeals, disciplinary actions, etc.
6.8	Miscellaneous	Attendance at medical staff/department meetings Various organizational committee service Thank-you letters

7. An organization may maintain credentialing files in their original paper form, scanned form, digitalized form, or any other electronic storage medium, as approved by the organization.
8. Credentialing files are confidential documents and should be treated as such by being housed in the medical staff services office under lock and key. Care must be taken by the medical staff services professional to protect the confidentiality of the contents of the credentialing files they are working on in the presence of others.
9. The credentialing files must be kept up to date. If the facility ever faces questions regarding the practitioner's competence or performance, the credentialing file will assist the organization in fulfilling its obligations to the patient and its defense against legal action.
10. An up-to-date credentialing file contains the following information:
    a. Required medical staff and department meeting attendance;
    b. Current licensure;
    c. Current malpractice liability insurance;
    d. Disciplinary actions/sanctions, including periodic queries of the OIG exclusions list;
    e. Certifications;
    f. Continuing medical education if an attestation statement is not in use;
    g. Medical staff and performance improvement committee service;
    h. NPDB status;

i. Quality/performance improvement and utilization review data;
j. Any other information required by the organization.

11. The medical staff services professional or medical staff services office personnel shall supervise the review of any credentialing file. Access to files should be limited to the following persons**:**
    a. Designated office staff members processing credentialing information;
    b. Consultants or attorneys engaged by the organization;
    c. Representatives of regulatory or accreditation agencies;
    d. A practitioner may review his/her own file under the following conditions:
        i. The request is approved by the chief executive officer (CEO), department chair, president of the medical staff, or Credentialing Committee chair.
        ii. The review is accomplished in the presence of the medical staff services office coordinator, a member of the Credentialing Committee, or officer of the staff.
        iii. The physician understands nothing may be removed from the credentialing file.
        iv. Nothing may be photocopied without permission of the CEO.
        v. An explanation note or document may be added to the file.
        vi. Confidential letters of reference received during initial appointment or at reappointment may NOT be reviewed.
    e. The chairperson of the Credentialing Committee;
    f. The risk manager, as necessary to perform his/her functions;
    g. Other persons authorized by the CEO.
12. Any external requests for credentialing information shall not be honored pending referral to administration.
13. Credentialing files may be periodically purged to eliminate the overall volume of documents contained therein. The policy and procedures for document retention, archiving, and destruction should be followed. For example, information from previous appointment period, such as letters thanking practitioners for serving on committees, outdated CME files, and other extraneous documents not pertinent to the appointment/reappointment process, may be purged from the file.
14. Medical staff services professionals gather information on the applicant's past education, training, licensure, current competence, malpractice history, etc. Carefully checking and cross checking all of the materials housed in the credentialing files is an important step performed by the medical staff services office personnel. Identification of discrepancies or "red flags" must be brought to the attention of the credentialing chair and the department

chair/chief of staff. Preparing an administrative summary of the contents of the credentialing file, when complete, is an excellent practice and may be submitted with the credentialing file to the Credentialing Committee.

15. As necessary and appropriate, provisions for the storage of medical staff credentialing files in the event of a merger, acquisition, or closure of the facility will be followed. Developing a policy that is unique to the facility and addresses these concerns is appropriate. In the event of a closure, the state or local medical society may provide direction and assistance with credentialing files.