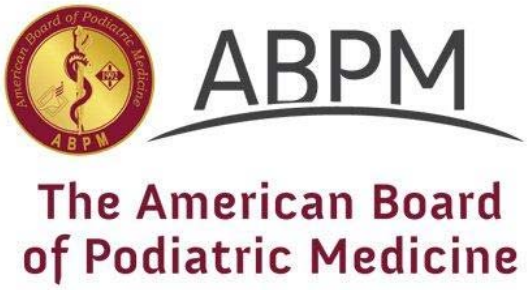

A Guide to Credentialing and Privileging Doctors of Podiatric Medicine

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Introduction

Credentialing and privileging requirements and processes vary by state and hospital. Accordingly, requirements within specialties change as healthcare needs and educational requirements advance. This guide is intended to provide credentialers with an overview of nuanced changes in the podiatry profession and to provide podiatrists with an understanding of the purpose and requirements related to hospital and health system credentialing and privileging processes. Knowledge of both the requirements and the internal functions will assist both credentialers and podiatrists navigate the sometimes-confusing processes more effectively.

How to use this guide

The first section of this guide explains, in detail, the elements that typically comprise an effective credentialing and privileging process complete with the rationale for best practices and compliance requirements for the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission on Hospital Accreditation ("The Joint Commission"). While the information in this document could apply to all specialties, we have inserted information specific to podiatry to illustrate how this relates to their credentials and experience. This document can also assist your departments update or review internal criteria based on expanded educational and residency requirements in the podiatric profession.

This guide includes the following appendices to provide hospital credentialers and ABPM members with useful guidelines and reference points related to credentialing and privileging activities of Doctors of Podiatric Medicine (DPMs).

- Appendix A: 16 Best Practice Elements for Credentialing Excellence
- Appendix B: Comparison of CMS and The Joint Commission credentialing and privileging requirements
- Appendix C: APMA Guidelines for Privileging
- Appendix D: Core Privileging Recommendations for Doctors of Podiatric Medicine

We acknowledge that not all organizations share the same criteria and may look for different elements depending on what their individual medical staff feels is appropriate, in addition to federal and state regulations. We also hope the updated and clear outline of information contained herein will provide those credentialing bodies mired in ongoing updates in the changing world of medicine with a succinct yet comprehensive update and reference for credentialing and privileging DPMs. Well-written, current policies (including privileging documents) provide for the effective management of many difficult issues, allowing for the fair treatment of all parties involved.

Credentialing vs. Privileging

Credentialing is a straightforward function designed to validate the minimum qualifications needed to practice medicine and for *membership* on a medical staff. Its counterpart – *privileging* – is a more complex process designed to protect patients, the healthcare organization, and the practitioner through authorization of a defined scope of practice with associated eligibility criteria; both for the new applicant and for the practitioner with existing privileges to maintain or renew their privileges on a regular basis.

Criteria for membership and criteria for privileges should be separate and distinct. Membership and Privileges are two separate decisions and are not inherently linked in that (per policy) an individual practitioner can have membership without privileges (e.g. Community Staff, Honorary Staff), privileges without membership (e.g. APRNs, PAs or perhaps telemedicine or locum tenens providers). *Membership* categories define by policy the assigned member's functions such as being eligible to vote, the right to hold office, access to the hospital CME programs, and the level of participation in the organized medical staff 's responsibilities.

Minimum elements to qualify for membership typically include:

- Current license;
- Education
- Board certification (NOTE: Alternatively board certification may be a privileging requirement instead of a membership requirement if such certification is applicable to specific privileges only and not required of all members);
- Insurance coverage;
- Record free from sanctions or criminal conduct;
- Character and ethics references.

Membership categories and the definition of the type of practitioner who may be a member of the organized medical staff and associated prerogatives are not uniform across hospitals. Sometimes the same term for a particular staff category may have a different meaning at a different facility. For this reason, despite the fact that it can be burdensome to read the Medical Staff Bylaws in their entirety, it is recommended that at a minimum, applicants familiarize themselves with the nuances contained within the Medical Staff Bylaws related to membership categories and associated prerogatives, eligibility criteria for membership and clinical privileges, timeframes and the procedure for initial appointment and reappointment.

Membership qualifications specific to a podiatric physician may be as follows:

- *Successfully complete a residency program approved by the Council on Podiatric Medical Education (CPME), the credentialing body recognized by the American Podiatric Medical Association (APMA) and*
- *Be board certified or become board certified by the American Board of Podiatric Medicine (ABPM) or the American Board of Foot and Ankle Surgery (ABFAS).*

TIP: It is up to the hospital to determine what length of time after the completion of formal training to require board certification, if at all, but note that the two CPME-recognized boards give candidates longer than the industry standard five (5) years to complete the process.

Privileging is a mechanism to facilitate a practitioner's clinical practice via a patient centered and risk adverse approach that takes into account an applicant's **education**, **training**, and current **experience** to perform a specific set of privileges or an individual procedure and is a mechanism for the authorization to practice through the organized medical staff with approval by the governing body. Criteria-based privileging is a requirement of CMS and all other accrediting agencies with deemed status granted by CMS i.e., The Joint Commission, DNV GL, Healthcare Facilities Accreditation Program (HFAP) and others.
Specifically, the CMS Conditions of Participation Interpretive Guidelines §482.12 (a)(6) The process articulated in the medical staff bylaws, rules, or regulations must include criteria for determining the privileges that may be granted to individual practitioners and a procedure for applying the criteria to individual practitioners that considers:

- Current clinical competence;
- Individual training including residency and fellowship training, post graduate certification of training and/or preceptorship;
- Individual experience or ongoing clinical practice in the privileges requested/granted; and
- Individual judgment.

Often all of the qualifications for membership noted previously apply with additional specificity related to the applicant's ability to perform privileges (health status), recent experience specific to the privileges requested, and (in many hospitals) a requirement for board certification in their primary area of practice. For the podiatrist, both the American Board of Podiatric Medicine and the American Board of Foot and Ankle Surgery are recognized by the Council on Podiatric Medical Education's (CPME) Joint Committee on the Recognition of Specialty Boards (JCRSB) and indicate the demonstration of a cognitive knowledge of a special area of practice. CMS Conditions of Participation prohibits the use of board certification as the only criteria for qualification for privileges.

CMS: §482.12(a)(7): Ensure that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship, or membership in a specialty body or society.

TIP: This does not mean that a hospital is prohibited from requiring board certification but it may not be the sole factor.

One of the most difficult jobs of medical staff leadership is developing the right privileging approach. An important first step is recognizing the benefits of well-designed and well-maintained criteria-based process. Privileging is a fluid activity and as such, privileging content (scope and eligibility qualifications) must be reviewed and updated (as applicable) on a recurring basis as determined by changes in the field and/or the complexity or evolution of the practice area. The evolution of podiatric education to today's higher standards is a perfect example. Privilege delineations should be reviewed annually to ensure that they continue to reflect contemporary practice and industry standards.

One of the most effective means of meeting the requirement for criteria-based privileging is through the use of a core privileging methodology. Many organizations have developed and implemented a criteria-based core privileging system to:

- ➢ Simplify the process for the applicants by clearly stating the criteria and services/procedures offered
- ➢ Establish consistency by requiring all practitioners within a clinical specialty / subspecialty to meet minimum threshold criteria.
- ➢ Reduce focus on seldom-used privileges by placing the focus on like skills and techniques necessary to perform requested procedures.
- ➢ Assist the medical staff leadership (Department Chairs and Credentials Committee) by clearly defining minimum threshold criteria that allows for objective, evidence-based decision making.

A successful core privileging system that meets accreditation requirements should include:

- ➢ Predefined criteria for each privilege (whether core or non-core) that outlines specific education, training and experience requirements
- ➢ Descriptions of clinical privileges and accompanying procedures lists as applicable that are accurate, detailed, comprehensive and specific
- ➢ A system that is designed to avoid denials by clearly stating the minimum education, training, experience, and current competence required to apply for specific clinical privileges
- ➢ A mechanism for opting out of particular privileges or procedures within the core by the applicant if they don't wish to request them or wish for them to be granted.

Privileging qualifications specific to a podiatric physician may be as follows:

- *Successfully complete a residency program approved by the Council on Podiatric Medical Education (CPME), the credentialing body recognized by the American Podiatric Medical Association (APMA) and*
- *Be board certified or become board certified by the American Board of Podiatric Medicine (ABPM) or the American Board of Foot and Ankle Surgery (ABFAS).*

TIP: It is up to the hospital to determine what length of time after the completion of formal training to require board certification, if at all, but note that the two CPME-recognized boards give candidates longer than the standard five (5) years to complete the process.

- *Required Current Experience: Demonstrate current competence and evidence of at least [n] podiatric procedures reflective of the scope of privileges requested during the past 24 months.*

TIP: Organizations may require additional proctoring for applicants who do not meet established criteria to demonstration competence for requested privileges.

Roles and responsibilities

Typically, the decision makers in credentialing include service or division chiefs, department chairs, credentials committee members, medical executive committee members, and the governing board. It is their job to make sure that the practitioners appointed to their medical staffs and granted clinical privileges are up to the institution's standards—in skill sets and competencies, background, experience, character, judgment, and professionalism. Anything less would put patients at risk, and the entire organization as well. Individuals or groups/committees at every level in the process should feel empowered to question the details and make certain that they resolve all concerns to their satisfaction before making any recommendations for membership or privileges. All decision makers make recommendations to the governing board, who is responsible for managing the financial assets and the quality and safety of care at every healthcare organization. The governing board has the ultimate authority and makes the decision whether to grant, deny, or modify the request for membership and/or clinical privileges.

Healthcare credentialing professionals aka medical services professionals (MSPs), management, and executives are key players in any healthcare organizations and bear a huge responsibility to effectively support and resource the credentialing and privileging functions. The board of directors places the safety of patients and of the hospital in the hands of its CEO, and who ultimately makes decisions on how the organization can mitigate the risks associated with granting clinical privileges.

> **NOTE:** Podiatry may be in its own hospital department or under another department such as general surgery, vascular surgery, or plastic surgery.

External and Internal Influencers

The task of tracking all the requirements for proper credentialing can be a daunting one. Depending upon the type of organization, the external 'masters' they are accountable to, and their own internally defined considerations, the requirements can vary widely.

Credentialing and privileging are required functions driven by federal (CMS) and state laws and regulations (e.g., Healthcare Quality Improvement Act), as well as the healthcare organization's applicable accrediting body e.g., The Joint Commission, DNV GL, HFAP, Center for Improvement in Healthcare Quality (CIHQ), and others who have been granted deemed status by CMS. For podiatrists, rules and requirements regarding their scope of practice vary from state to state, making it impossible to apply a single privileging standard across different parts of the country.

In addition to the external factors mentioned above, policies and procedures driving the workload and output of credentialing and privileging activities are also controlled by internal documents i.e., bylaws, rules, regulations, policies and procedures of each facility's legally-constituted, organized

medical staff. This accounts for the variation across separately organized and licensed hospitals whether connected within a healthcare system or operating under an entirely different non-associated structure. Ideally, today's organizations working to standardize the credentialing and privileging function in health care systems must also look to rationalize and standardize the medical staff dependent policies and procedures driving the credentialing and privileging function.

Appendix A: 16 Best Practice Elements for Credentialing Excellence

Credentialing has no master; other than the patient

A comprehensive credentialing process is crucial in protecting patients, the healthcare practitioner, and the healthcare organization against negligent credentialing claims. Best practices in the industry are intended to help hospitals and other healthcare organizations prepare for increased scrutiny by private and regulatory agencies in charge of overseeing patient safety. Credentialing practices should not be static and should be reviewed periodically for the inclusivity of elements to minimize risks to the patient, the healthcare organization, and healthcare practitioners.

Most hospitals and healthcare organizations seek to do the right thing and recognize that the credentialing process is not about achieving minimal compliance with regulatory or accreditation requirements for credentialing. Those that understand the critical responsibility of credentialing and privileging go beyond compliance requirements and provide a framework for further inquiries into a practitioner's background.

A highly effective credentialing process reduces both costs and risks to the patient, the institution, and the practitioner, increases efficiency, enhances revenue, and—most importantly of course—improves patient care. No practitioner should be allowed to provide patient care until he or she has successfully satisfied the requirements of a stringent qualification—or disqualification, as the case may be—process. Organizations collect the appropriate information (e.g., formal education, training, certification, experience, and demonstrated current competence) and then verify that information through primary sources to ensure that what the practitioner provided is valid. The 16 elements for credentialing excellence that follow are widely recognized as industry best practices and go beyond
elements mandated by federal, state, and regulatory agencies.

ELEMENT 1: Licensure, registration, history

Summary: At the time of initial appointment or initial privileges, verify the applicant's licensure, registration history, including sanctions. Source verify all current licenses. At reappointment or renewal of privileges, source verify all current licenses, and review the National Practitioner Data Bank (NPDB) to assess for adverse licensing or registration actions.

Rationale: Applicants may have had one or more of their state-issued licenses revoked, suspended, or otherwise restricted. For example, some medical staff candidates possess a valid license to practice medicine, osteopathy, oral surgery, or podiatry but may have had a license to practice as a pharmacist, registered nurse, etc., previously revoked or restricted.

ELEMENT 2: Lifetime clinical education and training history

Summary: At the time of initial appointment or initial privileges, verify the applicant's clinical education and training history, including CPME approved podiatric training as well as all residency and fellowship programs relevant to licensure as a podiatrist. For newly requested privileges, verify additional education and training related to the specific privileges requested which may include didactic training as well as simulation, animal or cadaver labs, or supervised training on human subjects (preceptorship).

Rationale: Required by CMS and accrediting bodies. Organizations may elect to perform additional source verifications.

ELEMENT 3: Professional liability insurance and claims history

Summary: Collect and evaluate claims history and medical malpractice insurance information as follows:

- At the time of initial appointment or initial privileges, obtain the applicant's attested current medical malpractice coverage and previous 10-year claims and settlement history, including pending cases, cases dismissed with prejudice, claims, lawsuits, and settlements (include those brought against the practitioner's professional corporation or incorporated practice) on the initial application.
- Review the medical malpractice coverage face sheet submitted by the applicant to assess whether there is coverage for requested clinical privileges and if current coverage meets the organizations minimum requirements for coverage (i.e., 1 million minimum/3 million aggregate)
- Review settlement history on the NPDB
- At the time of reappointment or renewal of privileges, review the same elements for the prior two years.

Rationale: Assessing this aspect of clinical practice is an industry standard. Although the presence or absence of a malpractice suit indicates little about a practitioner's current clinical competence, malpractice suits may indicate potential problems if such suits occur in large numbers, are clustered within a certain diagnosis or procedure, or result in extremely high court awards. A number of dismissed cases could be an indicator of less-than-optimal physician-patient relationships.

Medical staff leadership may set a threshold for adverse trend criteria that may disqualify and applicant.

ELEMENT 4: Specialty board status

Summary: At the time of initial appointment or initial privileges, source verify the applicant's specialty board status (no status or certified) Confirm annual compliance with maintenance of certification, as applicable. It is common for organizations to include time limited language such as "Be or become board certified in podiatric medicine within 5 years of completion of training and maintain certification thereafter."

Specialty board certification distinctions for Doctors of Podiatric Medicine (DPM)

- The Council on Podiatric Medical Education (CPME), under the authority of the American Podiatric Medical Association (APMA), recognizes two specialty boards in podiatry, the American Board of Podiatric Medicine (ABPM) and the American Board of Foot and Ankle Surgery (ABFAS). The terminology used by these boards differs from MD and DO boards.
- The ABPM and ABFAS have two parts to their examination, called qualification (part 1) and certification (part 2).
- In podiatry, **board eligible** means that a candidate completed a CPME-approved postgraduate training program and is eligible to sit for the board qualification exam. **Board qualified** means the candidate successfully passed part I of the examination and is eligible to sit for part II, the board certification exam. **Board certified** means that a candidate successfully passed both parts of the examination. ABFAS also requires successfully passing a case review process.
- The ABPM requires a candidate sit for the qualification exam within five (5) years of completion of training and then sit for the certification exam within five (5) years of achieving board qualified status (maximum time to become board certified by ABPM is ten (10) years post residency).
- The ABFAS has no timeline for when a candidate must sit for part 1, but specifies that once board qualified, the process must be completed in seven (7) years.

Rationale: While the certification or lack of certification of the applicant does not, in and of itself, indicate clinical competence, certification does show that the applicant has demonstrated a complete grasp of the knowledge and skills necessary to perform effectively. Increasingly, medical staffs are requiring that applicants have board certification or are board eligible (as defined by the applicable specialty board) and obtain their certification within a timeframe specified in the medical staff bylaws.

One excellent benchmark of a physician's medical knowledge and skills is whether he/she took an exam and received certification from a recognized specialty board. This benchmark should be evaluated by all individuals undertaking credentialing even when board certification is not a required qualification for membership or clinical privileges.

NOTE: Both CPME-recognized boards have changed their names in recent years.

- The American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM) is now doing business as the American Board of Podiatric Medicine (ABPM).
- The American Board of Podiatric Surgery (ABPS) is now doing business as the American Board of Foot and Ankle Surgery (ABFAS).

TIP: Ensure that Medical Staff bylaws, department policies, and privileging documents are updated to reflect the new board names.

ELEMENT 5: Sanctions and disciplinary actions

Summary: At the time of initial appointment or initial privileges, investigate all sanctions or disciplinary actions taken, recommended, or pending against an applicant by a hospital, health system, component of a health system, freestanding ambulatory care facility, and any branch of the federal or state government, specialty board, or managed care organization or payers. Thereafter, investigate sanctions and disciplinary actions per organizational policy. Most organizations utilize the NPDB along with application disclosures as the primary source documents for this activity.

Rationale: Thousands of physicians have been disciplined by the DOJ, OIG, HHS, the Drug Enforcement Agency, state-specific Controlled Dangerous Substances agencies, or the combined 50 state licensing boards or by private organizations, such as hospitals, managed care organizations, surgery centers, ambulatory care centers, and specialty boards.

While the vast majority of the physicians in the United States have never had any disciplinary action taken against them, healthcare managers have more reasons today than ever to be concerned about identifying physicians with problem backgrounds. A history of committing fraud or of jeopardizing patient safety is not only dangerous to patients, but fraught with legal liability risks as well.

ELEMENT 6: National Practitioner Data Bank (NPDB)

Summary: Query the NPDB, as applicable, at the time of initial appointment or initial privileges (including additional/new privileges) and every two years thereafter. Subscription to the NPDB Continuous Query (CQ) service is recommended.

Rationale: The Healthcare Quality Improvement Act of 1986 established the NPDB, with the intent of improving the quality of healthcare by establishing a national repository that would restrict the ability of physicians and dentists with issues of competency or behavior from moving state to state without discovery or disclosure of negative information in their backgrounds (e.g., malpractice settlements and disciplinary actions).

Hospitals are required by federal law to query the NPDB at the time of initial requests for medical staff membership or initial requests for clinical privileges (including additional/new privileges) and every two years thereafter. The NPDB is utilized as source documentation for several areas of clinical practice.

ELEMENT 7: Lifetime criminal record

Summary: Check the applicant's lifetime (or legally obtainable) criminal history at the time of initial appointment or initial privileges. At the time of reappointment, renewal of privileges, or a return from a leave of absence, organizations should check the practitioner's criminal history per organizational policy. Some organizations limit this investigation of criminal history to time since graduation from medical school in all jurisdictions where the applicant has had a residence and utilize a background report purchased from a recognized agency in combination with disclosures on the application as source documentation. The organization should set criteria for actionable information (i.e. does a Class 1 Felony or DUI disqualify an applicant?).

Rationale: Thousands of physicians have now been convicted or pled guilty to a crime or felony charge. Physicians who have been convicted or pled guilty to a crime or felony are often (but not always) required to cease practice by a state medical board. By not allowing certain physicians to practice medicine, medical boards are demonstrating their concern that such doctors have committed crimes serious enough to have affected hospital liability, the safety of patients, or the integrity of practice.

At one time, it was nearly impossible, or cost-prohibitive, to obtain well-documented information on criminal, civil, and malpractice history. Now, the information is readily available to healthcare institutions and for little cost (relative to the risk of not conducting background checks) and time.

ELEMENT 8: Verification of identity

Summary: At the time of initial appointment or initial privileges, confirm the applicant's identity by submitting a recent photograph of the applicant to professional references. If your organization is accredited by the Joint Commission, a representative must view the practitioner's government-issued ID and document that it is a match to the applicant. Verification of identity is not necessary at reappointment. (Note: The Joint Commission also allows for viewing of another hospital ID badge.)

Rationale: The news is full of victims of identity theft. A quick Google search will reveal several disturbing headlines of individuals pretending to be healthcare practitioners. Healthcare organizations need to take the necessary precautions to protect patients and the organization and avoid these embarrassing headlines.

ELEMENT 9: All* healthcare-related employment/appointment history

Summary: At the time of initial appointment or initial privileges, include application questions to verify the applicant's healthcare-related employment, appointment, and privilege history, including terminations, challenges, pending investigations or decisions, voluntary or involuntary resignation, relinquishments of medical staff membership, clinical privileges, or panel appointments, and termination, cessation, or non-renewal of employment contracts. At the time of reappointment or renewal of privileges, ask the same types of questions and verify healthcare-related employment/ appointment history per organizational policy. *For locum tenens and telemedicine practitioners, verify the applicant's healthcare-related employment/appointment history per organizational policy.

Rationale: Many physicians have had disciplinary actions taken against them by hospitals, payers, or ambulatory care centers. Interruptions in a practitioner's employment history serve as "red flags" of possible clinical incompetence or problems with integrity or behavior. The following suggest the need for further scrutiny or inquiry:

- Multiple job/appointment changes during a relatively short period of time
- Resignations from medical staffs
- Dismissals from employment positions or termination of contracts, including medical groups or partnerships
- Termination of medical staff membership, privileges, or appointment

It is only through a rigorous check of employment and appointment history that you can be reasonably assured of identifying all prior sites of practice or employment, conducting a gap analysis, and, to a certain extent, investigating the quality of the applicant's work. In addition, applicants who have changed job locations frequently must be subjected to greater investigation than those who have had a relatively stable employment/appointment history. While there are often logical reasons for changing locations frequently during a career, there are also instances in which such moves suggest a problem that may not have risen to the level of formal disciplinary action.

ELEMENT 10: Peer references from individuals who can attest to current clinical competency for privileges requested (e.g., Program Director, Department Chair, Service Chief)

Summary: Per organizational policy, obtain peer references who have recent knowledge of the applicant's clinical competence (within the past two years) utilizing a criteria-based questionnaire at the time of initial appointment or initial privileges. At the time of reappointment or renewal of privileges, obtain peer references only when there is insufficient clinical activity at your organization on which to conclude evidence of clinical competence. Many organizations allow the applicant to designate who will serve as a peer reference for them. However, it is recommended that at least one reference be from an authoritative source. A Department Chair at a an organization where the applicant currently practices the privileges that they are requesting is an example of an authoritative peer reference. Also if the applicant has recently graduated from their training program in the past 2 years, the training director may serve as an authoritative peer reference.

Rationale: There is no substitute for recommendations provided by knowledgeable practitioners concerning an applicant's current clinical competence and health status. No individual should be recommended for appointment or clinical privileges in the absence of newly obtained references confirming adequacy of medical and clinical knowledge, technical and clinical skill, clinical judgment, interpersonal skills, communication, professional performance, adherence to rules and bylaws, and health status (ability to perform requested clinical privileges). There should be virtually no exception to this process.

If there is anything that would be considered a yellow or red flag in a returned reference, then there should be no hesitation to seek additional information. Physician-to-physician conversations are typically more productive if there is any indication of a clinical or behavioral issue that needs additional scrutiny.

ELEMENT 11: Clinical activity for the past 24 months

Summary: Require a summary report of past 24 months of clinical activity (including the approximate number, type of procedures and conditions, and location of patients treated) as part of the initial or renewal request for clinical privileges. At the time of initial privileges, the timeframe of the summary report will depend on the applicant's level of clinical activity. For re-applicants who have had little clinical activity, seek information from external sources. Applicants who do not appear to fully satisfy criteria may need to undergo a period of preceptorship prior to applying. If case logs are required organizations may accept a clinical activity report from the applicant's professional fee billing system. This type of report captures cases performed across all practice locations. This information in combination with an authoritative peer reference will assist in answering both the question of ongoing clinical practice and quality of care provided.

Rationale: References attesting to excellent judgment in the area of surgery—coupled with a report demonstrating that the applicant has performed the type of surgery in question and an adequate number of surgeries—permit a credentials committee to formulate a complete recommendation. A report outlining the general scope of the applicant's clinical experience during the preceding 6 to 24 months augments the information provided from peer references and confirms whether their experience is reflective of clinical privileges requested.

Conversely, if an applicant displays significant experience in a particular field but does not back the experience with professional references and good clinical outcomes, that applicant has failed to demonstrate current clinical competence.

ELEMENT 13: Physical ability to perform requested privileges

Summary: Confirm that patient safety and quality are adequately ensured by assessing the health status (ability to perform requested privileges) of each practitioner at the time of initial and renewal of clinical privileges. Applicant's answers to questions on the application are typically used to identify potential issues where health status may interfere with the exercise of clinical privileges. Once identified these candidates are typically referred for separate confidential processing by a special committee or other mechanism to evaluate/conclude whether any problems exist. This assessment typically runs parallel to the credentialing/privileging process but is not part of it. Organizational policy will dictate where/when the two processes dovetail.

Rationale: In addressing privileges, medical staffs are obligated to establish an approach to assess each practitioner's capacity to perform all requested privileges including any mental or health concerns that have the potential to adversely affect their ability to perform some or all of their requested privileges. The American Medical Association defines the impaired provider as "one who is unable to practice medicine with reasonable skill and safety to patients because of a physical or mental illness, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs including alcohol."

ELEMENT 14: Internet search

Summary: Conduct an Internet search at the time of initial appointment and initial privileges to determine if other pertinent information (positive or negative) is available regarding the applicant. At the time of reappointment, renewal of privileges, and upon return from a leave of absence, conduct an Internet search per organizational policy. This is not a requirement by CMS or accrediting bodies.

Rationale: This is a simple activity and does not have to be difficult or time-consuming. While some may argue the point that this may seem duplicative to conducting a background check, more and more employers and credentialers are utilizing social media as a part of their due diligence process.
The offer of employment to practitioners may be predicated on incriminating or negative content outside the scope of a background check as more and more organizations are seeking to determine whether the practitioner is a good fit for them.

ELEMENT 15: Establish consistent practices for employed and non-employed practitioners

Summary: Verification elements should apply equally to employed and non-employed applicants for membership and clinical privileges. If state law mandates a requirement for employment, organizations should consider applying the same requirement to non-employed practitioners.

Rationale: It would be difficult for any organization to defend why they performed a background check for an employed pediatrician but did not do one for the non-employed pediatrician who turned out to be a pedophile. While state laws and hospital policies differ, protecting the patient should be the foremost consideration. By federal law, several types of workers are required to have random drug screens.

The case of David Kwiatkowski, who was a medical technician and prescription drug addict and left a trail of 45 unexplained hepatitis C cases, including two deaths, raises the question about whether hospitals should be required to perform random drug tests on all healthcare workers with access to drugs.[1]

ELEMENT 16: Assess verified applicant information for internal consistency and compliance with medical staff credentialing and privileging criteria

Summary: Compare all of the applicant's collected and verified information to ensure that there are no discrepancies and that the applicant meets the medical staff 's pre-approved credentialing and privileging criteria at the time of initial appointment, reappointment, and requests for clinical privileges. Summarize for review by physician leaders, committees, and the board.

Rationale: The task of reviewing and cross-checking information in the applicant's file is complex and time-consuming; therefore, a clear report of the information is necessary. This assessment is one of the most crucial functions that the medical services professional performs related to the practitioner's file. It is this analysis of the file that requires critical thinking and application of credentialing skill sets and experience to make sure that the information collected is complete, contains no discrepancies, and meets the predefined credentialing and privileging criteria.

A committee will rarely have time to carefully review and cross-reference an average credentials file against such documents as the American Medical Association Profile to search for previous state licenses or ones not listed by the applicant. Nor should committee members have to take the time to peruse through the entire file in order to determine if any of the candidate's licenses was ever subject to disciplinary action.

[1] Daniel R. Levinson and Erika T. Broadhurst, *Why Aren't Doctors Drug Tested?*, OIG HHS OpEd Column, March 2014.

Appendix B: Comparing CMS and The Joint Commission Credentialing/Privileging Requirements

Often there are questions raised as to what is actually ***required*** to be collected from an external compliance perspective. The following grid compares the initial appointment / initial privileging requirements of CMS and The Joint Commission (TJC) in an easy-to-understand format.

Practitioners included
Commonalities: • CMS and TJC allow the governing body (in accordance with State law) to determine other types of practitioners who may be eligible for appointment to the medical staff and/or granted clinical privileges. • Individuals do not need to be granted medical staff membership in order to be granted clinical privileges. **Specific requirements:** • **CMS:** Requires the medical staff at a minimum be composed of physicians (defined as MD/DOs). Others may be included as defined in the Social Security act i.e., podiatrists, dentists, chiropractors, optometrists. • **TJC:** All licensed independent practitioners must be credentialed and privileged through the organized medical staff structure including APRNs and PAs functioning as a LIP / providing a medical level of care.
Current licensure and registration
Commonalities: • CMS and TJC require primary source verification (PSV) of current licensure (state of current practice or intended practice). • CMS and TJC allow a copy of the DEA or CDS to suffice for verification **Specific requirements:** • **TJC:** The organized medical staff evaluates any challenges to any registration as well as the voluntary and involuntary relinquishment of any registration.

Education and training
Commonalities: • CMS and TJC require verification of completed education and training. • Primary Source Verification is preferred but designated equivalent sources are acceptable. Verification of all medical or professional schools *attended* is not required. **Specific Requirements:** • **TJC:** Allows for primary source verification of licensing to suffice for verification of education and training if **none** of the following are important to the healthcare entity: location of school, the marketing of educational status, or currency of education and training to clinical privileges. Typically, these are important elements to a hospital and/or healthcare entity and they are going to verify the education and training either through the originating source or a designated equivalent source.
Professional liability insurance and claims history
Commonalities: • CMS and TJC have no specific requirement for PSV of professional liability coverage (or an assessment of appropriate coverage for requested clinical privileges) although if the organization requires coverage, some type of verification is expected. • CMS and TJC have no specific requirement for PSV of claims history. **Specific Requirements:** • **TJC:** The medical staff must evaluate…evidence of unusual patterns or excessive numbers of professional liability actions resulting in a final judgment. A query of the NPDB (which contains information re: malpractice judgments/ settlements) is required.
Board certification status
Commonalities: • CMS and TJC do not require board certification for membership or clinical privileges • CMS and TJC require verification of board certification <u>if</u> the organization requires certification or recertification **Specific requirements:** • **CMS: §482.12(a)(7):** Ensure that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship, or membership in a specialty body or society. This does not mean that a hospital is prohibited from requiring board certification, but it may not be the sole factor.

Sanctions and disciplinary actions
Commonalities: • CMS and TJC do not specifically address verification of Medicare and Medicaid Sanctions but there is an expectation to adhere to all regulations (local, state, federal). • CMS and TJC do not specifically address verification of disciplinary actions taken, recommended, or pending against an applicant by a hospital, health system, component of a health system, freestanding ambulatory care facility, and any branch of the federal or state government, specialty board, or managed care organization or payers.
National Practitioner Data Bank (NPDB)
Commonalities: • Federal law (The Healthcare Quality Improvement Act) requires query of the NPDB when granting initial clinical privileges and additional privileges—and every two years thereafter. Continuous Query (CQ) is accepted by CMS and The Joint Commission. If the organization is an authorized healthcare entity, it must query the NPDB. **Specific requirements:** • None for this element
Lifetime criminal record
Commonalities: • CMS and TJC do not specifically require that organizations obtain a lifetime (or legally obtainable) criminal record. Federal and state regulations must be followed, and some states require a criminal background check. **Specific Requirements:** • **TJC:** Human resource standards require a criminal background check be addressed by policy for employees including employed practitioners e.g., physicians, advanced practice nurses, physician assistants.
Verification of identity
Commonalities: • None **Specific Requirements:** • **TJC:** Requires viewing the practitioner's government-issued ID prior to any patient care, with documentation that it is a match to the applicant. • **CMS:** Does not address verification of identity as a requirement.

Healthcare related work history
Commonalities: • CMS and TJC do not specifically mention a requirement for verification of work history. Most healthcare organizations will ask a series of questions on the application related to work history and then confirm the accuracy of the information with the healthcare entities and a gap analysis as applicable. **Specific Requirements:** • **TJC:** Application statement includes information regarding voluntary or involuntary termination of medical staff membership and voluntary/involuntary limitation, reduction, or loss of clinical privileges at another healthcare organization.
References
Commonalities: • CMS and TJC all require that professional references be obtained during initial appointment / initial requests for privileges. **Specific Requirements:** • **CMS:** Requires supporting references for confirming competence of the initial applicant • **TJC:** Requires PSV verification of professional and clinical performance at initial appointment. The process must include peer references. Peer recommendation includes written information regarding the practitioner's current medical/clinical knowledge, technical/clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism.
Clinical activity / experience
Commonalities: • CMS and TJC do not require that a summary report of clinical activity be obtained at the time of initial appointment. • CMS and TJC require PSV of experience driven by the CMS requirement for an evaluation of an individual applicant's character, competence, experience, training, and judgment. **Specific Requirements:** • **CMS:** Conditions of participation and interpretative guidelines do require examination of documented experience • **TJC:** Requires evidence of current competence and expects organizations to obtain information regarding licensure (or registration), education, training, experience, and competence.

Performance assessment

Commonalities:

- CMS and TJC require some type of performance monitoring or assessment be conducted once a practitioner is granted clinical privileges. They do not require that you request and obtain the specific results of performance assessment data or monitoring from a training program or previous or current practice locations during the initial appointment or initial privileges process.

Specific Requirements:

- **CMS:** The medical staff must at regular intervals appraise the qualifications of all practitioners appointed to the medical staff/granted medical staff privileges.
- **TJC:** Requires confirmation of competence for initial privileges granted through a focused professional practice evaluation (FPPE).

Ability to perform requested privileges (health status)

Commonalities:

- CMS and TJC address health status.

Specific Requirements:

- **CMS:** There is one comment in the surgical services section of the Conditions of Participation that states that a written assessment of the practitioner's health status is required.
- **TJC:** Applicants must submit a statement that no health problems exist that could affect ability to perform the privileges requested. The medical staff must evaluate documentation of evidence of physical ability to perform requested privilege. Documentation regarding an applicant's health status must be confirmed.

Internet search

Commonalities:

- CMS and TJC do not require that an internet search be conducted.

Specific requirements:

- None for this element

Consistent practices for employed and non-employed

Commonalities:

- CMS and TJC do not address establishing consistent practices for employed and non- employed practitioners. However, the expectation is that the same standard of care is provided to patients whether they are treated by an employed practitioner or a non- employed practitioner.

Specific requirements:

- None for this element

Process for comparison, assessment, and summation of verified information
Commonalities: • CMS and TJC do not specifically address the *process* for assessing and summarizing the file for review. They require that the credentialing and privileging process, timeframes, and consideration by the medical staff and the governing body would be as outlined within the bylaws or related medical staff documents. **Specific Requirements:** • None for this element

Appendix C: Excerpt from the American Podiatric Medical Association (APMA) regarding hospital privileging and board certification

In the context of hospital privileging and credentialing, APMA supports granting clinical privileges to podiatrists based on the individual's training, education, and experience within the legal scope of practice of the respective jurisdiction. Stringent clinical privileges that do not fully delineate the expertise of podiatrists limit the public's access to timely and quality healthcare. On the same note, hospital bylaws governing services provided by podiatrists should also be reflective of the clinical ability and standard of care of podiatric medicine in the jurisdiction in question.

The Council on Podiatric Medical Education (CPME) is an autonomous accrediting agency for podiatric medical education. The Council on Higher Education Accreditation and the U.S. Secretary of Education recognize CPME as the accrediting agency for first professional degree programs in podiatric medicine. Deriving its authority from the House of Delegates of the American Podiatric Medical Association, CPME is empowered to develop and adopt standards and policies as necessary for the implementation of all aspects of its accreditation, approval, and recognition purview.

Specialty Board Certification
Board certification indicates that a podiatrist has demonstrated a cognitive knowledge of a special area of practice. The CPME, through the Joint Committee on the Recognition of Specialty Boards (JCRSB), is responsible for monitoring specialty certifying boards in podiatric medicine. JCRSB recognition of certifying boards in podiatric medicine is analogous to the role played by the American Board of Medical Specialties (ABMS) in its recognition of more than 20 specialty boards in medicine.

CPME currently recognizes two certifying boards: The American Board of Podiatric Orthopedics and Primary Podiatric Medicine (doing business as the American Board of Podiatric Medicine, or ABPM) and The American Board of Podiatric Surgery (doing business as the American Board of Foot and Ankle Surgery, or ABFAS)

For more information:

American Board of Podiatric Medicine: www.abpmed.org

American Board of Foot and Ankle Surgery: www.abfas.org

American Podiatric Medical Association: www.apma.org

Council on Podiatric Medical Education: www.cpme.org

Appendix D: Core Privileging Recommendations for Doctors of Podiatric Medicine

DELINEATION OF PRIVILEGES
PODIATRIC MEDICINE AND SURGERY

Core I – General Privileges in Podiatric Medicine and Surgery
Core II – Elective Soft Tissue and Osseous Procedures in Podiatric Medicine and Surgery
Core III – Trauma and Reconstructive Procedures in Podiatric Medicine and Surgery
Core IV - Amputation Prevention and Wound Care Procedures in Podiatric Medicine and Surgery

Special privileges:
Ankle Replacement/Implant
Conscious Sedation
Supervision of Hyperbaric Oxygen Therapy (HBOT)

Education
1. Doctor of Podiatric Medicine (DPM) degree from a Council on Podiatric Medical Education (CPME) approved college

Training
1. Successful completion of a CPME-approved residency. Since 2011, all podiatric residents complete a 36-month Podiatric Medicine and Surgery Residency (PMSR or PMSR/RRA). Prior to 2011, CPME-approved residencies had the following designations; Podiatric Medicine and Surgery - 24 month or 36 months (PM&S-24, PM&S-36), Podiatric Surgical Residency 12, 24, or 36 months (PSR), Podiatric Orthopedic Residency (POR), Primary Podiatric Medicine Residency (PPMR), or Rotating Podiatric Residency (RPR). 2. Board eligible, board qualified, or board certified by one of the two CPME-recognized certifying boards (the American Board of Podiatric Medicine (ABPM) or the American Board of Foot and Ankle Surgery (ABFAS) -- with achievement of certification within 5 years following completion of all postgraduate training.

Experience

- Be board certified or become board certified by the American Board of Podiatric Medicine (ABPM) or the American Board of Foot and Ankle Surgery (ABFAS).
- Documentation of case logs from residency, fellowship, and practice
  - In cases where experience cannot be documented, proctoring is recommended to demonstrate experience.
- Active privileges at other facilities
- Peer references

Core I - General Privileges in Podiatric Medicine and Surgery

Privileges

Admit, evaluate, diagnose, provide non-surgical and surgical care to patients of all ages presenting with injuries and disorders of the foot and ankle including soft tissues below the tibial tuberosity. Surgical privileges include nail and soft tissue procedures. The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.

Core I privileges include the following categories and types of procedures, but not to be an all-encompassing list:

1. Nail procedures
2. Soft tissue procedures
3. Wound debridement
4. Simple incision and drainage

Core II - Elective Soft Tissue and Osseous Procedures in Podiatric Medicine and Surgery

Privileges

Forefoot reconstructive procedures, fracture care of the phalanges and metatarsals and simple rearfoot procedures.

Core II privileges include the following categories and types of procedures, but not to be an all-encompassing list:

1. Fracture and dislocation of the phalanges and metatarsals
2. Excision of soft tissue masses
3. Bunion procedures
4. Hammertoe correction
5. Bone spur resection
6. Soft tissue and bone biopsy
7. Toe amputations

Core III - Trauma and Reconstructive Procedures in Podiatric Medicine and Surgery

Privileges

Surgical privileges include rearfoot and ankle reconstructive procedures including arthrodesis and fracture care.

Core III privileges include the following categories and types of procedures, but not to be an all-encompassing list:

1. Osteotomies
2. Arthrodesis
3. Tendon repair and transfer
4. Flaps and grafts
5. Fracture management
6. Arthroscopy

Core IV - Amputation Prevention and Wound Care Procedures in Podiatric Medicine and Surgery
Privileges
Medical and surgical management of infections, gangrene and wounds of the lower extremity, including amputations and limb salvage. Core IV privileges include the following categories and types of procedures, but not to be an all-encompassing list: 1. Multi-level debridements and incision and drainage 2. Advanced wound technologies, grafts, devices 3. Partial foot amputations 4. Charcot foot and ankle management 5. Osteomyelitis resection and management

Special Privileges in Podiatric Medicine and Surgery
Privileges
Special privileges to perform the following procedures require documentation of additional training and experience. 1. Ankle Replacement/Implant 2. Conscious Sedation 3. Supervision of Hyperbaric Oxygen Therapy (HBOT)

See published guidelines for credentialing doctors of podiatric medicine in the supervision of HBOT.[1]

1. Rogers LC, DellaCorte MP, Stavosky JW, Millington JT, Capotorto JV. Credentialing guidelines for doctors of podiatric medicine supervising hyperbaric oxygen therapy a position paper. *J Am Podiatr Med Assoc.* 2015;105(4):367-370.

Sample Podiatric Medicine Privilege Delineation

Delineation of Privileges

Applicant's Name:

Instructions:

1. Check the **Request** checkbox to request a group of privileges such as *Primary Privileges* or a Privilege Cluster.
2. Sign form and submit with any required documentation.
3. All applicants for initial privileging or renewal of privilege must submit a case log reflecting ongoing clinical practice in the privileges requested during the previous two years.

Required Qualifications	
Education/Training	Successful completion of a minimum of 24-month CPME residency program in podiatric medicine and surgery (post completion of a four year college/school of podiatric medicine) in a program approved by the Council on Podiatric Medical Education (CPME) OR documentation of ongoing clinical practice and current clinical competence in the privileges requested.
Certification	Current certification by the American Board of Podiatric Medicine (ABPM) OR American Board of Foot and Ankle Surgery (ABFAS) within 5 years of completion of training.
Clinical Experience (Initial)	Applicant must provide documentation of provision of podiatric services (# cases) representative of the scope and complexity of the privileges requested during the previous two years (or completion of formal training with documentation of clinical competence in the privileges requested during the previous two years).
Clinical Experience (Reappointment)	Applicant must provide documentation of provision of clinical services (# cases) representative of the scope and complexity of the privileges requested during the past 24 months.

Core Privileges in Podiatry

Request ☐	*Request privileges listed below by checking request box.*	Div Chief Rec ☐	Dept Chair Rec ☐
☐	Admit patients in conformance with State licensing and organizational requirements. (Note: Some organizations may modify the delineation to "Co-admit" consistent with State or organizational requirements.)	☐	☐
☐	Perform history and physical examination	☐	☐
☐	Evaluate, diagnose, provide consultation to patients and provide non-operative treatment for diseases, injuries and complaints involving the foot and ankle in conformance with scope of licensure.	☐	☐
	General Procedures		
☐	Local infiltration anesthetic injection including basic blocks	☐	☐
☐	Soft tissue surgery involving a nail or plantar wart excision, avulsion of toenail, excision or destruction of nail matrix, removal of foreign body	☐	☐
	Surgical Privileges for the Forefoot, Midfoot and Non-reconstructive Hind Foot		
☐	Onychoplasty	☐	☐
☐	Debridement of ulcer	☐	☐
☐	Excision of soft tissue mass (neuroma, ganglion, fibroma)	☐	☐
☐	Digital surgery including digital exostectomy; digital fusions; tenotomy/capsulotomy; open/closed reduction of digital fracture; syndactylization and polydactylism; digital tendon transfers, lengthening, repair	☐	☐
☐	Metatarsal surgery including open/closed reduction of fractures; metatarsal exostectomy; metatarsal osteotomy	☐	☐
☐	Excision of sesamoids	☐	☐
☐	Tenotomy/capsulotomy, metatarsal, phalangeal joint	☐	☐
☐	Hallux valgus repair with or without metatarsal osteotomy (including 1st metatarsal cuneiform joint)	☐	☐
☐	Midtarsal and tarsal exostectomy (include posterior calc spur)	☐	☐
☐	Excision of benign bone cysts and bone tumors, forefoot	☐	☐
☐	Plantar fasciotomy with or without excision of calc spur	☐	☐
☐	Neurolysis of forefoot nerves	☐	☐
☐	Treatment of deep wound infections, osteomyelitis	☐	☐
☐	Metatarsal excision	☐	☐
☐	Tendon lengthening	☐	☐
☐	Endoscopic plantar fasciotomy	☐	☐
☐	Implant arthroplasty forefoot	☐	☐

Privilege Cluster: Complex Procedures Including Reconstructive Rearfoot and Ankle Surgery Procedures

Qualifications	
Education/Training	Successful completion of a 36-month residency program in podiatric medicine and surgery (post completion of a four year college/school of podiatric medicine) in a program approved by the Council on Podiatric Medical Education (CPME) OR a minimum of a 24-month residency with documentation of ongoing clinical practice and current clinical competence in the specific privileges requested.
Certification	Current certification by the American Board of Podiatric Medicine (ABPM) or by the American Board of Foot and Ankle Surgery (ABFAS) within 5 years of completion of training.
Clinical Experience (Initial)	Applicant must provide documentation of provision of podiatric services (# cases) representative of the scope and complexity of the privileges requested during the previous two years (or completion of formal training with documentation of clinical competence in the privileges requested during the previous two years).
Clinical Experience (Reappointment)	Applicant must provide documentation of provision of clinical services (# cases) representative of the scope and complexity of the privileges requested during the past 24 months.
Additional Qualifications	Must qualify for and be granted primary privileges in podiatry **AND** NOTE: Insert any special limitations in scope of practice/licensure or special permits that may exist in a specific State. Also privileges listed may require further modification to conform with State specific requirements.

Request ☐	***Request privileges listed below by checking request box.***	Div Chief Rec ☐	Dept Chair Rec ☐
☐	Neurolysis or nerve decompression, rearfoot	☐	☐
☐	Open/closed reduction of foot fracture other than digital or metatarsal excluding calcaneal	☐	☐
☐	Selection, harvesting or application of basic grafts	☐	☐
☐	Excision of benign bone cyst or bone tumors, rearfoot	☐	☐
☐	Tarsal coalition repair	☐	☐
☐	Tendon rupture repair	☐	☐
☐	Excision of accessory ossicles, midfoot and rearfoot	☐	☐
☐	Tenodesis	☐	☐
☐	Osteotomies of the midfoot and rearfoot	☐	☐
☐	Tendon transfers	☐	☐
☐	Rearfoot fusion	☐	☐
☐	Arthrotomy	☐	☐
☐	ORIF and closed reduction of rearfoot and calcaneal fractures	☐	☐
☐	External fixation (multiplane) confined to the foot	☐	☐
	Ankle procedures		
☐	Treatment of fractures with or without instrumentation	☐	☐
☐	Tendon and ligament repair	☐	☐
☐	Diagnostic arthroscopy	☐	☐

☐	Therapeutic arthrosocpy including debridement and soft tissue repair	☐	☐

Privileges in Hyperbaric Medicine

Description: Note: These privileges are for basic and localized wound treatment. The delineation does not include privileges for treating complications that might be associated with deeper dives, complex cases or critically ill patients.

Qualifications	
Education/Training	Completion of a training program in hyperbaric oxygen therapy (HBOT) of 40 hours approved by the Undersea and Hyperbaric Medical Society (UHMS) or the American College of Hyperbaric Medicine that was followed by supervised cases on human subjects.
Clinical Experience (Initial)	Applicant must provide documentation of provision of hyperbaric medicine services (# cases) representative of the scope and complexity of the privileges requested during the previous two years (or completion of formal training with documentation of clinical competence in the privileges requested during the previous two years).
Clinical Experience (Reappointment)	Applicant must have provided clinical services (# cases) representative of the scope of privileges requested during the past 24 months.

Request ☐	***Request privileges listed below by checking request box.***	**Div Chief Rec** ☐	**Dept Chair Rec** ☐
☐	Evaluation, diagnosis and therapeutic management utilizing hyperbaric oxygen therapy to patients for acceleration of wound healing, vascular impairment and treatment of soft tissue and bone infection limited to State specific podiatric scope of practice.	☐	☐
	Wound Healing Center Privileges (Note: This section is only required if the organization has a separate Wound Center where separate privileges are required (closed unit). If this is not the case this cluster can be removed and the privilege holder may rely on routine procedural privileges to authorize practice.)		
☐	Superficial and sharp debridement; wound closure; and general care for wounds including performance of topical or field infiltration of anesthetic solutions. Select and apply appropriate wound dressings including liquid or spray occlusive materials, removal of drains, application of immobilizing dressing (soft or rigid).	☐	☐
☐	Sharp/surgical debridement of deep wounds including muscle and bone.	☐	☐
☐	Selection/harvesting and application of basic grafts	☐	☐

Moderate (Procedural) Sedation

Description: Default to organization policy and definition. The following definition is provided as an example: Moderate Sedation/Analgesia ("Conscious Sedation") is a drug-induced depression of consciousness. No interventions are required to maintain a patent airway, spontaneous ventilation is adequate and cardiovascular function is maintained.

Qualifications	
Education/Training	The applicant must provide evidence of training and supervised experience during residency and/or fellowship OR if training occurred greater than 1 year ago the applicant must provide evidence of ongoing clinical practice.

Clinical Experience (Initial) Applicant must provide documentation of provision of clinical services representative of the scope and complexity of the privileges requested during the previous two years OR successfully pass the organization sponsored Moderate Sedation exam to qualify for initial privileging.

Clinical Experience (Reappointment) Applicant must provide documentation of provision of clinical services representative of the scope and complexity of the privileges requested during the previous 24 months OR successfully pass the organization sponsored Moderate Sedation Exam.

Additional Qualifications Current ACLS certification (will skills demonstration) or demonstration of successful completion of airway management simulation lab.

Request ☐	***Request privileges listed below by checking request box.***	Div Chief Rec ☐	Dept Chair Rec ☐
☐	Supervision and administration of Moderate Sedation in conformance with organizational policy	☐	☐

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I believe that I am competent to perform and that I wish to exercise at -- Insert Organization Name -- and I understand that:

A. In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Practitioner's Signature _____ Date _____

Department Chair Recommendation - Privileges

I have reviewed the requested clinical privileges and supporting documentation and my recommendation is based upon the review of supporting documentation and/or my personal knowledge regarding the applicants performance of the privileges requested:

☐	Recommend all requested privileges
☐	Do not recommend any of the requested privileges
☐	Recommend privileges with the following conditions/modifications/deletions (listed below)

Privilege	Condition/Modification/Deletion/Explanation

Department Chair Recommendation - FPPE Requirements

Signature of Division Chief/Designee

Date

Signature of Department Chair/Designee

Date

Submit