Keeping up with ASC credentialing

Staying on top of credentialing and privileging requirements in an ambulatory surgery center (ASC) is a daunting task. Credentialing applications need to be tracked; licensure, education, and other qualifications verified; databases checked for suspensions and any other adverse actions; and reappointments followed up.

ASC leaders know accreditation surveyors expect all files to be complete and up-to-date. The Accreditation Association for Ambulatory Healthcare (AAAHC) and the Joint Commission have extensive credentialing and privileging requirements.

The standards are not easy to meet. In fact, privileging (HR.02.01.03) was the top Joint Commission compliance issue for ambulatory care organizations for the first half of 2009 (related article, p 29). For AAAHC-accredited facilities, some of the biggest challenges are primary source verification and reappointment.

**Primary source verification**

Verifying primary sources for licensure, medical school graduation, and other qualifications is a key requirement of both the Joint Commission and AAAHC standards.

Some facilities aren’t clear about what primary source verification is, observes Jack Egnatinsky, MD, an anesthesiologist and AAAHC accreditation expert.

“A number still just have a copy of the [physician’s] license in the file and think that is sufficient for primary source verification, and it isn’t,” he says.

One acceptable way to document primary sources for physicians is to use the AMA Profile Service, which provides data on state licensure, medical school, board certification, and so forth.

“Using the AMA profile does provide evidence of most primary source verifications. You have to look at each section individually,” Dr Egnatinsky says. The profile indicates whether the verification is provided by the primary source or the individual.

Some states, such as Arizona, also have physician profile services. See the sidebar (p 28) for more resources.

One option, though costly, is to use a credentials verification organization (CVO), a company that takes care of primary source verification. But you still need to monitor their services, Dr Egnatinsky notes.

“Some CVOs are accredited, and some are not. Just because they are not accredited does not mean they are not doing a thorough job. You need to do due diligence.”

**What’s needed for reappointment?**

Another common shortcoming is the reappointment process. The AAAHC standards require reappointment to the medical staff every 3
years. The Joint Commission requires privileges to be reviewed and renewed every 2 years. The Medicare Conditions for Coverage (CfCs) recommend reappraisal of privileges every 2 years.

Too often, reappointment is a casual activity, not a formal process, he notes.

“The standards call for an application for reappointment and a review of all the appropriate information, including a review of peer review reports and any adverse events,” he says. That includes checking for Medicaid and Medicare sanctions, DEA registration, and any information in the National Practitioner Databank.

**Are privileges complete?**

Privileging is the process for determining the procedures and treatments a facility will offer, the qualifications required to offer those services, and the process for evaluating clinicians’ requests for privileges.

Common flaws in the privileging process that AAAHC surveyors see are adopting privileging lists wholesale from a hospital, not clearly documenting that requests for privileges are reviewed, and overlooking some services that require privileges.

“The privilege list needs to be specific to the facility,” Dr. Egnatinsky says. “We often see operations on the privilege list that clearly cannot be done in an ASC at this time.”

In general, the privilege list needs to be completely updated at the time of reappointment. Facilities often have a process for amending the list between reappointments, either by having the practitioner submit a limited application or a specific request to the facility’s administrator or governing board, including documentation of education and experience for performing the procedure.

Dr. Egnatinsky recommends that persons reviewing requests initial the recommendation or indicate in some way that the request was reviewed and not merely rubberstamped.

Some areas tend to get overlooked for privileges. Among these are operating x-ray equipment, interpreting x-rays, and administering local anesthesia.

Privileges for x-ray are particularly important because of the expansion of pain management, and many physicians are reading and interpreting films who don’t have the privileges to do so, Dr. Egnatinsky says.

Regarding local anesthesia, he says, “under our current standards, this is required as a separate privilege in most instances.”

**Credentialing allied health providers**

All practitioners who provide services in the ASC who are not employees need to be credentialled, Dr. Egnatinsky advises. Examples are RN first assistants, physician assistants who come with surgeons, and others who may come occasionally, such as physical therapists and audiologists.

The requirement applies whether the practitioner is licensed or not. For example, technicians who come with ophthalmologists need to be credentialled.

**What’s the minimum for procedures?**

What do you do about privileges for a practitioner who performs a procedure rarely? For instance, a surgeon has performed only 2 rhino-
plasties at your ASC in the past 2 years. Should the surgeon’s privileges for that procedure be renewed?

There is no uniform answer.

“Some organizations have a minimum number of procedures they feel they need. But the minimum varies,” says Dr Egnatinsky.

One ASC, for example, required a physician to perform at least 50 of each privileged procedure for every 2-year reappointment. Many physicians didn’t meet that. As an alternative, a physician had to provide a log of the procedures done elsewhere, including any complications or problems.

Other facilities don’t have a minimum. But he points out that in order to perform peer review, the facility needs documentation that the individual is competent to perform the procedure and may rely on recommendations from other organizations.

For facilities that have a minimum of 5 to 10 cases, it becomes difficult if individuals don’t meet that, he notes.

He says he surveyed 2 facilities in the past year where physicians did not have privileges renewed because they did not meet the required minimum. When he asked why, the facility responded that it didn’t make sense to maintain privileges for a person who is only going to perform a couple of the procedures every 2 years. Maintaining a credentialing file is expensive.

Though there is no uniform answer, Dr Egnatinsky says, “I think most organizations, particularly with the requirement that peer review be looked at at the time of reappointment, are looking for some sort of minimal activity level so they can meet both the peer review and the credentialing standards.”

—Pat Patterson

Practical tips for managing records

Here are some points from experts on managing the process of credentialing and privileging.

**Batch reappointments**

Group reappointments and licensure expirations and if possible do them annually or semi-annually, suggests Gayle R. Evans, RN, MBA, CNOR, CASC, of Continuum HealthCare Consultants, Kennesaw, Georgia.

For example, reappointments for the first quarter of 2010 would be done in 2009.

“That way, you can put everyone on a schedule, rather than having to remember that Dr Jones needs reappointment this month and Dr Smith next month,” she says.

**Use online services**

The AMA Profile Service from the American Medical Association offers online credentials verification in 5 areas:

- medical school
- graduate medical education
- board certification
• state licensure
• Drug Enforcement Administration registration.
  The profile can be considered primary source verification. There is a minimal charge.
  Using the AMA profile and the National Practitioner Databank covers primary source verifications.

**Highlight expiration dates**
  In credentialing files, highlight expiration dates on copies of licenses, DEA certificates, malpractice insurance, etc, so you can spot them easily.

**Consider a standardized application**
  Many states have a standardized credentialing application. Using that instead of inventing your own saves work, Evans says. “You can have the physician’s office send you the completed state application, signed and dated, for each accreditation cycle.” A new application must be verified for each cycle.

**Keep a tickler file**
  Automated calendars like Microsoft Outlook allow you to set up reminders on your computer to check expiration dates for licenses, certifications, and other credentialing information, notes Sharon Kimbrough, CPCS, assistant administrator of the Outpatient CareCenter, Birmingham, Alabama.

**Be a detective**
  No matter how organized you are, some information takes persistence and time to track down, Kimbrough says. An example is an education program that has closed. She recalls having to track down a school where a certified registered nurse anesthetist had graduated. The school had been sold. After calling 5 hospitals, she finally found someone who knew the name of the new program. The American Association of Nurse Anesthetists maintains a database of accredited nurse anesthesia education programs at http://webapps.aana.com/AccreditedPrograms/accreditedprograms.asp?ucNavMenu_TSMenuTargetID=222&ucNavMenu_TSMenuTargetType=5&ucNavMenu_TSMenuID=6

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**Definitions**

**Credentialing**
  The process of obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization.

**Privileging**
  A process whereby the specific scope and content of patient care services (that is, clinical privileges) are authorized for a health care practitioner by a health care organization based on evaluation of the individual’s credentials and performance.

*Source: Joint Commission.*
ASC credentialing resources

**American Medical Association**

*Profile Service*

The service provides physician data on medical school, graduate medical education, board certification, state licensure, and Drug Enforcement Administration registration. The AMA says all of these data elements may be used as primary source data. There is a charge.

—https://profiles.ama-assn.org/amaprofiles/

**National Practitioner Databank**

Created by law, the databank includes adverse actions against practitioners such as actions against licensure, privileges, professional society membership, and exclusions from Medicare and Medicaid.

—www.npdb-hipdb.hrsa.gov

**CertifACTS Online**

An official agent of the American Board of Medical Specialties, this online resource is considered the equivalent of a primary source for board certification data. There is a charge.

—www.certifacts.org

**Drug Enforcement Administration**

Database of registered individuals used for verification and credentialing. There is a charge.


**HHS Office of Inspector General**

Searchable database of individuals excluded from participating in federally funded health care programs, including Medicare and Medicaid.

—http://exclusions.oig.hhs.gov/