Many ASCs have received deficiency citations for medical staff credentialing and privileging over the last 2 years. This article will review the applicable CMS conditions and standards and best practices to ensure compliance.

**416.42 Condition for Coverage: Surgical Services**

Surgical procedures must be performed in a safe manner by qualified physicians who have been granted clinical privileges by the governing body of the ASC in accordance with approved policies and procedures of the ASC.

Physician is defined as a “doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, and a doctor of podiatric medicine” per the Social Security Act. The physician must be licensed in the state and practicing within the scope of his/her license. Privileges cannot be granted until the physician has been deemed qualified. The governing body is specifically responsible for reviewing applicant qualifications and granting privileges. The facility must have a written policy and procedure, which clearly defines this process and qualification criteria. In most cases this process is outlined in the medical staff bylaws.

**416.45 Condition for Coverage: Medical Staff**

The medical staff of the ASC must be accountable to the governing body.

While medical staff organization is discretionary, the governing body must have a clearly defined policy and process that defines how the medical staff is held accountable to the governing body. Medical staff privileges may be granted to non-physician providers, as long as those privileges are consistent with their permitted scope of practice in the state and supported by documented evidence of appropriate training and experience.

**416.45(a) Standard: Membership and Clinical Privileges**

Members of the medical staff must be legally and professionally qualified for the positions to which they are appointed and for the performance of privileges granted. The ASC grants privileges in accordance with recommendations from qualified medical personnel.

Privileges granted by the governing body must be specific, in writing, and may only be granted to those legally and professionally qualified. Legal qualification requires knowledge of the license scope of practice and verification of the license with the issuing authority in the state. Professional qualification means the applicant is competent to perform the requested privileges. Documentation of specialized training and experience is evidence of competence.
Additionally, the ASC is required to solicit the opinion of qualified medical personnel with knowledge of the applicant. This opinion must be in writing with supporting rationale. The reference source may be a member of the ASC medical staff or an outside physician with no connection to the ASC. In fact, in single-owner ASCs with only one physician on the medical staff, the opinion of an outside qualified medical professional is required. The governing body is not obliged to adhere to the recommendation of the outside professional; however, the rationale for making a decision to the contrary must be documented.

The processes by which the applicant is vetted and the governing body grants medical staff privileges must be consistent and thoroughly documented. Typically, the applicant submits the following to the ASC:

- Request for staff appointment
- Completed application including liability questionnaire with explanations when applicable
- Authorization to release information
- Completed “Privilege Request” form
- Copy of professional liability coverage with limits that meet or exceed facility requirements
- Copy of medical license, DEA permit, and other certifications (such as ACLS) as applicable
- Peer references

Once received, the ASC must verify the information and credentials provided by the applicant. This process is involved and requires great attention to detail. Large organizations may opt to use a credentialing verification organization (CVO) to complete the process. Once the files are complete, the documentation is delivered to the ASC for review and appointment.

Smaller organizations typically manage the credentialing process in house. Verification of education and training may be obtained from the primary sources, such as the educational institutions from which the applicant graduated. This is cumbersome and time consuming. Alternatively, verification may be obtained through a qualified secondary source. In the case of MDs, a physician profile from the American Medical Association (AMA) is acceptable as secondary source verification. To obtain AMA physician profiles, go to https://profiles.ama-assn.org/amaprofiles/ and click on “new customer registration.” The American Osteopathic Association provides this service for DOs. You can obtain AOA physician profiles at www.doprofiles.org/index.cfm.

Other credentials such as medical license and DEA permit must be verified through the appropriate state or federal issuing agency. Verification of hospital privileges must be done through the primary source. Many hospitals now allow you to manage this process online. The CMS standard specifically requires peer references. It is good practice to request at least three peer references and require a minimum of two completed peer references for review and consideration prior to appointment.

Additionally, the ASC must register with the National Practitioner Database-Healthcare Integrity Database as an Authorized Entity (NPDB) at www.npdb-hipdb.hrsa.gov/hcorg/register.jsp. Once registered, an NPDB query should be requested for the applicant and available for review by the credentials committee. This will document any settlements or judgments against the applicant.

Verification of exclusion from the Medicare/Medicaid program is obtained at the OIG website http://exclusions.oig.hhs.gov/. Basis for exclusion includes convictions for program-related fraud and patient abuse, licensing board actions, and default on Health Education Assistance Loans.

Once the verification process is completed, all of this documentation must be compiled and organized for presentation to the credentialing committee. The committee recommendation is forwarded to the governing body, which ultimately acts upon that recommendation by appointing the applicant to the medical staff.

**416.45(b) Standard: Reappraisals**

Medical staff privileges must be periodically reappraised by the ASC. The scope of procedures performed in the ASC must be periodically reviewed and amended as appropriate.

The term of appointment for medical staff membership is defined in the medical staff bylaws. CMS recommends the term not be longer than 2 years. Every 2 years, the staff member must reapply and his/her credentials must be reappraised. In addition, quality and peer review data must be documented and considered in the reappointment process. Based on this documentation, the ASC governing body may

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practice owns the space in which the ASC resides. Medicare has no authority to dictate to the practice how it utilizes its physical space apart from the ASC operation. They do have authority to dictate how the practice operates the ASC. I have a client who used the lobby for a wedding reception on a weekend. CMS would not have anything to say about that.

Where I have seen CMS push back on this concept is in a practice owned and adjacent to the ASC where the lines of distinction and demarcation between the practice and ASC operations are blurred or indistinct. Remember, the intent of this regulation is to preclude fraud and abuse—that is, to use the ASC space as clinic space but bill CMS a facility fee. This abuse most commonly occurs with a YAG laser located in the ASC. When it is used during non-operating ASC hours, yet billed as an ASC facility, that is fraud.

In the case of LASIK, fraud and abuse is not an issue. That said, CMS is very sensitive on this issue, and meeting the definition of an ASC as a distinctly separate entity from any other organization is the very first condition for coverage. Therefore, it is wise for ASCs utilizing their facility during non-ASC operating hours, for ANY PURPOSE, to make it a non-issue to a visiting surveyor. It should not be obvious in any way that would make the surveyors aware of the fact or prompt questions. It is a disadvantage if the excimer laser is located in the ASC. Easier for a roll on, roll off. If the excimer laser is located in the ASC, it should be used only on a day the ASC is not operating—this is cleaner than “splitting” a day between operations (a.m./p.m.). Staff should be clear on the regulations and understand how to respond to surveyors if questions about this issue surface.

I would steer clear of calling this an “exemption,” and I suspect this may be language that created a problem with CMS. CMS is very clear that there can only be one standard of care in a CMS-certified ASC—it is not dictated by the complexity of the procedure, the type of anesthesia, the reimbursement status, or the payer. There is no such thing as an exception or exemption in a Medicare-certified ASC.

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elect to reappoint the provider with no change to the current privileges granted or to amend those privileges in some way. In the case of a sole owner/single member medical staff, the reappointment process must include review and recommendation of outside qualified medical personnel.

**416.45(c) Standard: Other Practitioners**

*If the ASC assigns patient care responsibilities to practitioners other than physicians, it must have established policies and procedures, approved by the governing body, for overseeing and evaluating their clinical activities.*

Patient care responsibilities (which may or may not include formal medical staff privileges, but excluding nursing care services) may be assigned to licensed practitioners not meeting the definition of physician in §1861(r) of the Act. “Physician” is defined in §1861(r) of the Social Security Act as:

- Doctor of medicine or osteopathy;
- Doctor of dental surgery or of dental medicine;
- Doctor of podiatric medicine;
- Doctor of optometry with respect to services legally authorized to be performed in the State; and
- Chiropractor with respect to treatment by manual manipulation of the spine (to correct subluxation diagnosed by x-ray).

When non-physician practitioners provide patient care in the ASC, other than nursing care, the ASC must have clearly defined policies and procedures to establish a system for overseeing and evaluating the quality of the clinical services provided by those practitioners. In an ophthalmic ASC, the typical scenario involves the use of certified registered nurse anesthetists (CRNA) for anesthesia services. In such cases, the ASC must develop policies to define required qualifications, the credentialing process, scope of practice, oversight and supervision, and periodic reappraisal.

**Advice**

Failure to properly document and implement your credentialing and privileging process can result in at least two CMS condition level citations. If you have not visited this process recently in your ASC, it behooves you to review your medical staff bylaws, scope of care, privilege request forms, credentialing process, and peer review process to ensure your facility is in compliance with these conditions and standards.

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