2012 Annual Ambulatory Care Conference
Credentialing and Privileging
Questions and Answers

Revised March 13, 2014

The following questions and answers are the outcome of a presenter/audience dialogue at the 2012 Joint Commission Resources Ambulatory Care Conference which took place in Oak Brook, IL on November 8-9, 2012.

1. Question regarding Primary Source Verification:
   Delays in posting to website (10 days to process), and hitting significant resistance from states (we cover multiple states) when we call to follow-up, causes us to suspend staff until verified. Any chance The Joint Commission is able to make recommendations to states? Possibly a standardized letter could be provided?

   Answer:
   Your concern has been forwarded to appropriate Joint Commission leaders. Currently Primary Source Verification rests with the state who issues the license.

2. Question regarding staffing options:
   Organizations are saving money – using Medical Assistants (MA) vs. hiring extra nurses. There seems to be a lot of gray areas in relation to their scope of practice. Specifically, are Medical Assistants allowed to administer drops and start IV's in patients if they are monitored by an RN?

   Answer:
   Your state law and regulations determine licensure requirements. If allowed by state law, the MA’s education/training/state regulations/site policy and procedures/competency are all factored into the decision. RN licenses also determine if they can monitor unlicensed personnel to perform licensed tasks/procedures. Check your state law and RN license scope.

3. Question regarding FPPE compliance:
   How much and what kind of data needs to be collected for FPPE compliance?

   Answer:
   FPPE (Focused Professional Practice Evaluation) is required in Hospital Accredited programs only, not Ambulatory. Your organization determines methodology for documenting review of any clinical performance in the organization that is outside the acceptable standards. The content and amount of data is determined by your organization and typically reflects the privileges requested.

4. Question regarding OPPE: How many records/cases need to be reviewed per year for OPPE?

   Answer:
   OPPE (Ongoing Professional Practice Evaluation) is required in Hospital Accredited programs only, not Ambulatory. Your organization determines methodology for documenting ongoing evidence of the individual’s ability to perform the privileges requested. This can be peer or faculty recommendations or performance improvement activities pertaining to professional performance, judgment, and clinical or technical skills. The content and amount of data is determined by your organization and typically reflects the privileges requested.
Credentialing and Privileging

5. **Question regarding governance requirements:**
   Is there a governance requirement in terms of credentialing and privileging such as an Executive/Medical Credentialing committee, Medical Director, or Governing Board? Or can an organization decide how to approve credentialing and privileging?

   **Answer:**
   Ambulatory Care Program does not specify the form of governance for credentialing and privileging decisions. Your organization determines your process and approval structure for making those decisions.

6. **Question regarding peer references:**
   For both the initial and reappointment process, if we state in our bylaws that we only need one peer reference – then only one is acceptable; however is that allowed under HR02.01.03? EP 6 has the term “recommendations,” so does this mean we are required? EP 6 states: “The organization documents current evidence, which includes peer and/or faculty recommendations of the individual’s ability to perform the privileges requested.” Does the term “recommendations” indicate peer references are required?

   **Answer:**
   The Ambulatory program standard is not specific regarding number of peer references required. Your organization determines the number of references.

7. **Question regarding PPM:**
   Is it necessary to list PPM (Provider Performed Microscopy) as a part of privileging for LIP’s, or have a competency on file if training is a part of their medical or practitioner program?

   **Answer:**
   Provider Performed Microscopy procedures are classified as non-waived moderate complexity tests and are subject to the CLIA regulations for non-waived testing. The use of the credentialing and privileging process is not adequate to document the competence of independent practitioners to perform these tests. Regardless of whether or not Provider Performed Microscopy testing is included in the privileging documentation for providers, documentation is required of initial competence assessment prior to performing patient tests, competence assessment after six months of performing testing, and annually thereafter. The assessment must be performed using the six required procedures for assessment of competence of non-waived testing personnel.

   - Direct observations of routine patient test performance, including patient preparation, if applicable, and specimen collection, handling, processing, and testing
   - Monitoring, recording, and reporting of test results
   - Review of intermediate test results or worksheets, quality control, proficiency testing, and preventive maintenance performance
   - Direct observation of performance of instrument maintenance function checks and calibration
   - Test performance as defined by laboratory policy (for example, testing previously analyzed specimens, internal blind testing samples, external proficiency, or testing samples)
   - Problem-solving skills as appropriate to the job
Credentialing and Privileging

8. **Question regarding CVO:**
   Can a CVO (Credentials Verification Organization) do a single credentialing check on a surgeon and provide those results to more than one company? For example, Hospital A requests credentialing, ASC#2 requests credentialing. CVO checks and sends results to both orgs? Is there a problem with this example?

   **Answer:**
   CVO’s are an organization that provides information on an individual’s professional credentials. They provide information per their contracts with their customers. You may reference the definition and 10 principles of a CVO in the Glossary of the CAMAC (Comprehensive Accreditation Manual for Ambulatory Care).

9. **Question regarding EKG privileges:**
   Do surgeon’s and anesthesia staff have to be privileged to read EKG’s?

   **Answer:**
   Your organization determines the privileges granted. However an EKG is a procedure that typically is not in a privilege list for an LIP to perform. An LIP may need a privilege to interpret and treat the results of a diagnostic test.

10. **Question regarding onsite survey preparedness:**
   Would it be recommended to call prior to a survey if an ASC knows there are severe deficits in their credentialing processes? For example, recent leadership changes have found a lack of process and follow through and attempts are being made to get compliance in order.

   **Answer:**
   No, the onsite surveyor will evaluate compliance at time of survey. However, communication to the surveyor as you review the data will enhance the ability of the surveyor to completely evaluate your situation, and they can often offer education and advice. If you receive a Requirement for Improvement (RFI), you are required to complete an “Evidence of Standards Compliance”; at that time the Standards Interpretation Group will assist you in your corrective actions.

11. **Question regarding competency:**
   How do you determine competency for newly hired M.D.’s and other providers?

   **Answer:**
   Prior to offering privileges, a letter of recommendation by faculty or peer is considered. Ongoing evaluation and peer review, or a focused review may be employed by your leadership to assess competency of any/or new Licensed Independent Providers.

12. **Question regarding documentation:**
   Must you have separate documents for the job description and competency or can they be combined?

   **Answer:**
   You determine your process, they are separate requirements. However, competency is linked to the job responsibilities determined by leadership.
13. **Question regarding NP’s:**
   If you have a Nurse Practitioner (NP) in a state that cannot practice without supervision (direct), do you still grant them privileges?

   **Answer:**
   If the Nurse Practitioner role is providing medical services, then credentialing and privileging would be recommended. If the Nurse Practitioner is not making medical decisions, then he/she can be processed in the staff HR processes. For example, if a NP is providing evaluation and treatment to pediatric clinic patients, under protocols and supervision of a Pediatrician---then credentialing and privileging is necessary. If the NP is in the role of a clinic manager, or clinical infection control leader, staff HR processes would be appropriate.

14. **Question regarding licensure:**
   If an LJP has more than one license, e.g., New York and Pennsylvania, do you need to have an NPDB (National Practitioners Data Bank) query for each license (both are active)? If this is the initial credentialing period and one license is expired, should you get a NPDB query?

   **Answer:**
   Yes, NPDB query should be conducted if the provider is credentialed and providing services in multiple states.

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Questions may be submitted to the Joint Commission Standards Interpretation Group at any time by calling 630-792-5900, Option 6 for Ambulatory Care or by submitting a standards question submission form found on The Joint Commission website. Link to form: [https://web.jointcommission.org/sigsubmission/sigonlineform.aspx](https://web.jointcommission.org/sigsubmission/sigonlineform.aspx)