Orthopedic surgery

Background

The American Academy of Orthopaedic Surgeons (AAOS) defines orthopedics (also spelled orthopaedics) as the medical specialty that focuses on injuries and diseases of the musculoskeletal system, which includes bones, joints, ligaments, tendons, muscles, and nerves. Common procedures performed by orthopedic surgeons include arthroscopy, bone fusion, internal fixation, joint replacement, osteotomy, and soft tissue repair.

Orthopedic surgeons are familiar with all aspects of the musculoskeletal system, but many orthopedists specialize in certain areas, such as the foot and ankle, spine, hip, or knee. They may also choose to focus on specific fields such as pediatrics, trauma, or sports medicine, and some orthopedic surgeons may specialize in several areas, according to the AAOS.

Although many orthopedic surgeons focus their practice on specific areas of the body, the American Board of Medical Specialties recognizes the following subspecialties of orthopedic surgery:

➤ Orthopedic sports medicine
➤ Surgery of the hand (see Clinical Privilege White Paper, Practice area 160—Hand surgery)

The Accreditation Council for Graduate Medical Education (ACGME) requires five years of training in orthopedic surgery to qualify for certification. Candidates for certification must pass both a written and oral examination to achieve certification. Certification is offered through the American Board of Orthopaedic Surgery (ABOS).

The American Osteopathic Association (AOA) and the American Osteopathic Board of Orthopedic Surgery (AOBOS) also require five years of training in orthopedic surgery for candidates seeking certification. Candidates must pass written, oral, and clinical examinations to achieve certification.

Involved specialties

Orthopedic surgeons
Positions of specialty boards

ABOS

The ABOS offers certification in the specialty of orthopedic surgery, which includes the following areas:
- Pediatric orthopedics
- Sports medicine
- Joint replacement and surgery in arthritis
- Foot and ankle
- Hand surgery
- Shoulder and elbows
- Spine
- Trauma and fractures
- Musculoskeletal oncology
- Rehabilitation
- Arthroscopy and arthroscopic surgery

The ABOS also offers certification in the subspecialties of hand surgery and orthopedic sports medicine.

The ABOS publishes minimum educational requirements for board certification as part of its Rules and Procedures for Residency Education: Part I and Part II Examinations. These requirements stipulate that candidates for certification should have five years of accredited postdoctoral residency. The first postgraduate year (PGY-1) must include:
- A minimum of six months of structured education in monthly rotations of surgery to include multisystem trauma, plastic surgery/burn care, surgical intensive care, and vascular surgery
- A minimum of one month of structured education in at least three of the following—emergency medicine, medical/cardiac intensive care, internal medicine, neurology, neurological surgery, rheumatology, anesthesiology, musculoskeletal imaging, and rehabilitation
- A maximum of three months of orthopedic surgery

Beyond PGY-1, candidates should experience the following distribution of educational requirements:
- 12 months of adult orthopedics
- 12 months of fractures and/or trauma
- Six months of children’s orthopedics
- Six months of basic and/or clinical specialties

Orthopedic education should provide candidates with experience in the following areas:
- Children’s orthopedics
- Anatomic areas
To take the certifying examinations, candidates must satisfactorily complete and document the minimum educational requirements in effect when they first enrolled. Candidates must successfully complete both the written and oral examinations to achieve certification by the ABOS.

**AOBOS**

The AOBOS grants board certification in orthopedic surgery. To be eligible for certification from the AOBOS, applicants must meet the following requirements:

- Graduate from a college of osteopathic medicine accredited by the AOA
- Hold an unrestricted license to practice in the state or territory where his or her practice is conducted
- Conform to the standards set in the AOA Code of Ethics
- Be a member in good standing of the AOA for a period of at least two years prior to certification
- For training programs prior to July 1, 2008, applicants must complete an AOA-approved internship and four years of AOA-approved training in orthopedic surgery
- For training programs after July 1, 2008, applicants must complete five years of AOA-approved training in orthopedic surgery
- Provide documentary evidence of the performance of at least 200 major orthopedic procedures
- Practice within the specialty of orthopedics for at least 12 consecutive months subsequent to the required years of approved training
- Successfully pass written, oral, and clinical examinations

Certification from the AOBOS is valid for 10 years, after which surgeons must complete a recertification examination administered by the AOBOS.

**Positions of societies, academies, colleges, and associations**

**AAOS**

The AAOS provides CME courses and materials to residents, candidates, and fellows in orthopedic surgery. The American Association of Orthopaedic Surgery is a branch of the AAOS that engages in advocacy activities and health policies.

The AAOS publishes a position statement titled *Delineation of Clinical Privileges in Orthopaedic Surgery*. According to this position statement, “decisions regarding the granting of clinical privileges should be based upon a thorough consideration
of each individual’s qualifications rather than his or her identification with a specific profession.” The AAOS encourages hospital medical staffs to develop specific criteria to serve as a framework for evaluating practitioners. Criteria should address licensure, training, current competence, experience, and health status, according to the AAOS.

The AAOS notes that orthopedic surgeons who have successfully completed an ACGME-accredited residency program have met educational requirements in the areas of diagnosis and care of disorders affecting the bones, joints, and soft tissues of the upper and lower extremities, including the hand and foot; as well as the entire spine, specifically including intervertebral disks and the bony pelvis. Additionally, “orthopaedic education includes experience with all patient age groups, acute and chronic care, related clinical subjects including musculoskeletal imaging procedures, use and interpretation of clinical laboratory tests, use of prosthetics, orthotics, physical modalities and exercises, treatment of certain neurological and rheumatological disorders, and administration of local, regional, or spinal anesthesia,” according to the AAOS.

**American Orthopaedic Association**

The American Orthopaedic Association is an organization that emphasizes leadership in orthopedics. The American Orthopaedic Association offers leadership training to its members, who must make significant contribution to research, education, and the practice of orthopedic surgery. The American Orthopaedic Association does not publish specific guidelines regarding credentialing and privileging of orthopedic surgeons, nor does it publish competency requirements.

**ACGME**

The ACGME publishes *Program Requirements for Graduate Medical Education in Orthopaedic Surgery*, which state that the educational program should be 60 months in length. The first year of residency (PG-1) should include:

- A minimum of six months of structured education in general surgery, to include the following:
  - Multisystem trauma
  - Plastic surgery/burn care
  - Surgical intensive care
  - Vascular surgery
- A minimum of three months of structured education, with at least one month each in three or more of the following:
  - Anesthesiology
  - Emergency medicine
  - Internal medicine
  - Medical/cardiac intensive care
− Musculoskeletal imaging
− Neurological surgery
− Neurology
− Pediatrics
− Rehabilitation Rheumatology
− Pediatric surgery (if not already included in general surgery)

➤ A maximum of three months of orthopedic surgery

PG-2 through PG-5 years must include at least 36 months of rotations on orthopedic services; rotations on related services such as plastic surgery, physical medicine and rehabilitation, rheumatology, or neurological surgery are suggested but not required.

Each resident’s experiences should include the following:

➤ Diagnosis and management of adult and pediatric orthopedic disorders, including:
− Joint reconstruction
− Trauma, including multisystem trauma
− Surgery of the spine, including disk surgery, spinal trauma, and spinal deformities
− Hand surgery
− Foot surgery
− Athletic injuries
− Orthopedic rehabilitation
− Orthopedic oncology, including metastatic disease
− Amputations and post-amputation care

➤ Nonoperative outpatient diagnosis and care, including all orthopedic anatomic areas

➤ At least one half-day per week of outpatient clinical experience in physician offices or hospital clinics with a minimum of 10 patients per session on all clinical rotations

➤ Instruction in pre- and postoperative assessment as well as the operative and nonoperative care of general and subspecialty orthopedic patients

➤ Involvement in all aspects of outpatient care of the same patient

➤ Increasing responsibility for patient care, under faculty supervision

➤ Inpatient and outpatient experience with all age groups

Each graduating resident must log between 1,000 and 3,000 procedures.

AOA

The AOA publishes Basic Standards for Residency Training in Orthopedic Surgery. The guidelines state that residency programs in orthopedic surgery should be five years in length, and should provide residents with 250 major orthopedic surgical cases per year after the first year of residency. The first year of the
residency program should include the following rotation schedule, which may be scheduled as 12 one-month rotations or 13 four-week rotations:

➤ Two months or rotations of internal medicine
➤ One month or rotation of emergency medicine
➤ Three months or rotations of general orthopedic surgery
➤ One month or rotation of family practice
➤ Two months or rotations of non-orthopedic surgery or vascular, general trauma, basic wound, burn, plastics, urology
➤ One month or rotation of obstetrics or women’s health
➤ Two months or rotations of electives in any of the following areas:
  – General orthopedic surgery
  – Foot and ankle
  – Hand
  – Hip and knee
  – Shoulder and elbow
  – Spine
  – Sports medicine
  – Pediatrics or pediatric orthopedics
  – Anesthesiology
  – Radiology
  – Pain management
  – Neurology
  – Neurosurgery
  – Physical medicine and rehabilitation

The AOA recommends that residents in years two through five complete three months of training each year or 100 cases each year in the specific areas of hand, spine, and trauma. The AOA also recommends that residents in years two through five spend six months each year or perform 100 cases each year in the field of pediatrics.

The content of the second through fifth years of the residency program should also include progressive training based on:

➤ Current orthopedic literature in periodicals
➤ Surgical anatomy of common orthopedic procedures
➤ Children’s orthopedics, including congenital deformities
➤ Tumors of the musculoskeletal system

Residents are required to complete the following mandatory courses:

➤ Orthopedic pathology course, which must be a minimum of 20 academic hours
➤ Basic fracture course equivalent to the AOTrauma Course or the Orthopedic Fracture Association Course prior to the start of the third year
➤ Advanced trauma life support course prior to the start of the third year
Positions of accreditation bodies

CMS

CMS has no formal position concerning the delineation of privileges for orthopedic surgery. However, the CMS Conditions of Participation (CoP) define a requirement for a criteria-based privileging process in §482.22(c)(6) stating, “The bylaws must include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges.”

§482.12(a)(6) states, “The governing body must assure that the medical staff bylaws describe the privileging process. The process articulated in the 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:
➤ Individual character
➤ Individual competence
➤ Individual training
➤ Individual experience
➤ Individual judgment

The governing body must ensure that the hospital’s bylaws governing medical staff membership or the granting of privileges apply equally to all practitioners in each professional category of practitioners.”

Specific privileges must reflect activities that the majority of practitioners in that category can perform competently and that the hospital can support. Privileges are not granted for tasks, procedures, or activities that are not conducted within the hospital, regardless of the practitioner’s ability to perform them.

Each practitioner must be individually evaluated for requested privileges. It cannot be assumed that every practitioner can perform every task, activity, or privilege specific to a specialty, nor can it be assumed that the practitioner should be automatically granted the full range of privileges. The individual practitioner’s ability to perform each task, activity, or privilege must be individually assessed.

CMS also requires that the organization have a process to ensure that practitioners granted privileges are working within the scope of those privileges.

CMS’ CoPs include the need for a periodic appraisal of practitioners appointed to the medical staff/granted medical staff privileges (§482.22[a][1]). In the absence of a state law that establishes a time frame for the periodic appraisal, CMS recommends that an appraisal be conducted at least every 24 months. The purpose of the periodic appraisal is to determine whether clinical privileges or membership should be continued, discontinued, revised, or otherwise changed.
**The Joint Commission**

The Joint Commission has no formal position concerning the delineation of privileges for orthopedic surgery. However, in its *Comprehensive Accreditation Manual for Hospitals*, The Joint Commission states, “The hospital collects information regarding each practitioner’s current license status, training, experience, competence, and ability to perform the requested privilege” (MS.06.01.03).

In the introduction for MS.06.01.03, The Joint Commission states that there must be a reliable and consistent system in place to process applications and verify credentials. The organized medical staff must then review and evaluate the data collected. The resultant privilege recommendations to the governing body are based on the assessment of the data.

The Joint Commission introduces MS.06.01.05 by stating, “The organized medical staff is responsible for planning and implementing a privileging process.” It goes on to state that this process typically includes:

- Developing and approving a procedures list
- Processing the application
- Evaluating applicant-specific information
- Submitting recommendations to the governing body for applicant-specific delineated privileges
- Notifying the applicant, relevant personnel, and, as required by law, external entities of the privileging decision
- Monitoring the use of privileges and quality-of-care issues

MS.06.01.05 further states, “The decision to grant or deny a privilege(s) and/or to renew an existing privilege(s) is an objective, evidence-based process.”

The EPs for standard MS.06.01.05 include several requirements as follows:

- The need for all licensed independent practitioners who provide care, treatment, and services to have a current license, certification, or registration, as required by law and regulation
- Established criteria as recommended by the organized medical staff and approved by the governing body with specific evaluation of current licensure and/or certification, specific relevant training, evidence of physical ability, professional practice review data from the applicant’s current organization, peer and/or faculty recommendation, and a review of the practitioner’s performance within the hospital (for renewal of privileges)
- Consistent application of criteria
- A clearly defined (documented) procedure for processing clinical privilege requests that is approved by the organized medical staff
- Documentation and confirmation of the applicant’s statement that no health problems exist that would affect his or her ability to perform privileges requested
A query of the NPDB for initial privileges, renewal of privileges, and when a new privilege is requested

Written peer recommendations that address the practitioner’s current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism

A list of specific challenges or concerns that the organized medical staff must evaluate prior to recommending privileges (MS.06.01.05, EP 9)

A process to determine whether there is sufficient clinical performance information to make a decision related to privileges

A decision (action) on the completed application for privileges that occurs within the time period specified in the organization’s medical staff bylaws

Information regarding any changes to practitioners’ clinical privileges, updated as they occur

The Joint Commission further states, “The organized medical staff reviews and analyzes information regarding each requesting practitioner’s current licensure status, training, experience, current competence, and ability to perform the requested privilege” (MS.06.01.07).

In the EPs for standard MS.06.01.07, The Joint Commission states that the information review and analysis process is clearly defined and that the decision process must be timely. The organization, based on recommendations by the organized medical staff and approval by the governing body, develops criteria that will be considered in the decision to grant, limit, or deny a request for privileges. The criteria must be consistently applied and directly relate to the quality of care, treatment, and services. Ultimately, the governing body or delegated governing body has the final authority for granting, renewing, or denying clinical privileges. Privileges may not be granted for a period beyond two years.

Criteria that determine a practitioner’s ability to provide patient care, treatment, and services within the scope of the privilege(s) requested are consistently evaluated.

The Joint Commission further states, “Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privileges, or to revoke an existing privilege prior to or at the time of renewal” (MS.08.01.03).

In the EPs for MS.08.01.03, The Joint Commission says there is a clearly defined process facilitating the evaluation of each practitioner’s professional practice, in which the type of information collected is determined by individual departments and approved by the organized medical staff. Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege.
HFAP

The Healthcare Facilities Accreditation Program (HFAP) has no formal position concerning the delineation of privileges for orthopedic surgery. The bylaws must include the criteria for determining the privileges to be granted to the individual practitioners and the procedure for applying the criteria to individuals requesting privileges (03.01.09). Privileges are granted based on the medical staff’s review of an individual practitioner’s qualifications and its recommendation regarding that individual practitioner to the governing body.

It is also required that the organization have a process to ensure that practitioners granted privileges are working within the scope of those privileges.

Privileges must be granted within the capabilities of the facility. For example, if an organization is not capable of performing open-heart surgery, no physician should be granted that privilege.

In the explanation for standard 03.01.13 related to membership selection criteria, HFAP states, “Basic criteria listed in the bylaws, or the credentials manual, include the items listed in this standard. (Emphasis is placed on training and competence in the requested privileges.)”

The bylaws also define the mechanisms by which the clinical departments, if applicable, or the medical staff as a whole establish criteria for specific privilege delineation.

Periodic appraisals of the suitability for membership and clinical privileges is required to determine whether the individual practitioner’s clinical privileges should be approved, continued, discontinued, revised, or otherwise changed (03.00.04). The appraisals are to be conducted at least every 24 months.

The medical staff is accountable to the governing body for the quality of medical care provided, and quality assessment and performance improvement (03.02.01) information must be used in the process of evaluating and acting on re-privileging and reappointment requests from members and other credentialed staff.

DNV

DNV has no formal position concerning the delineation of privileges for orthopedic surgery. MS.12 Standard Requirement (SR) #1 states, “The medical staff bylaws shall include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to those individuals that request privileges.”
The governing body shall ensure that under no circumstances is medical staff membership or professional privileges in the organization dependent solely upon certification, fellowship, or membership in a specialty body or society.

Regarding the Medical Staff Standards related to Clinical Privileges (MS.12), DNV requires specific provisions within the medical staff bylaws for:

➤ The consideration of automatic suspension of clinical privileges in the following circumstances: revocation/restriction of licensure; revocation, suspension, or probation of a DEA license; failure to maintain professional liability insurance as specified; and noncompliance with written medical record delinquency/deficiency requirements

➤ Immediate and automatic suspension of clinical privileges due to the termination or revocation of the practitioner’s Medicare/Medicaid status

➤ Fair hearing and appeal

The Interpretive Guidelines also state that core privileges for general surgery and surgical subspecialties are acceptable as long as the core is properly defined.

DNV also requires a mechanism (outlined in the bylaws) to ensure that all individuals provide services only within the scope of privileges granted (MS.12, SR.4).

Clinical privileges (and appointments or reappointments) are for a period as defined by state law or, if permitted by state law, not to exceed three years (MS.12, SR.2).

Individual practitioner performance data must be measured, utilized, and evaluated as a part of the decision-making for appointment and reappointment. Although not specifically stated, this would apply to the individual practitioner’s respective delineation of privilege requests.

**CRC draft criteria**

The following draft criteria are intended to serve solely as a starting point for the development of an institution’s policy regarding this practice area. The core privileges and accompanying procedure list are not meant to be all-encompassing. They define the types of activities, procedures, and privileges that the majority of practitioners in this specialty perform. Additionally, it cannot be expected or required that practitioners perform every procedure listed. Instruct practitioners that they may strikethrough or delete any procedures they do not wish to request.

**Minimum threshold criteria for requesting privileges in orthopedic surgery**

**Basic education:** MD or DO

**Minimal formal training:** Successful completion of an ACGME- or AOA-accredited residency in orthopedic surgery, and/or current certification or active
participation in the examination process (with achievement of certification within \([n]\) years) leading to certification in orthopedic surgery by the ABOS or the AOBOS.

**Required current experience:** At least 100 general orthopedic procedures, including \([n]\)^2 procedures for trauma and fractures of the hips and knees, \([n]\) of the shoulders and elbows, \([n]\) of the feet and ankles, \([n]\) of the spine, \([n]\) of the hand, and \([n]\) musculoskeletal oncology procedures, reflective of the scope of privileges requested, during the past 12 months, or the demonstrated successful completion of an ACGME- or AOA-accredited residency or clinical fellowship within the past 12 months.

**References**

If the applicant is recently trained, a letter of reference should come from the director of the applicant’s training program. Alternatively, a letter of reference may come from the applicable department chair and/or clinical service chief at the facility where the applicant most recently practiced.

**Core privileges in orthopedic surgery**

Core privileges for orthopedic surgery include the ability to admit, evaluate, diagnose, treat, and provide consultation to patients of all ages to correct or treat various conditions, illnesses, and injuries of the extremities, spine, and associated structures by medical, surgical, and physical means, including but not limited to congenital deformities, trauma, infections, tumors, metabolic disturbances of the musculoskeletal system, deformities, injuries, and degenerative diseases of the spine, hands, feet, knees, hips, shoulders, and elbows, including primary and secondary muscular problems and the effects of central or peripheral nervous system lesions of the musculoskeletal system. Physicians may provide care to patients in the intensive care setting in conformance with unit policies. Core privileges also include the ability to assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include the following procedures and other such procedures that are extensions of the same techniques and skills:

- Performance of history and physical
- Hips and knees
  - Amputation surgery, including immediate prosthetic fitting in the operating room
  - Arthrocentesis, diagnostic
  - Arthrodesis, osteotomy, and ligament reconstruction of the major peripheral joints (excluding total replacement of joints)
  - Arthrography
  - Arthroscopy
  - Bone grafts and allografts
  - Closed reduction of fractures and dislocations
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- Debridement of soft tissue
- Excision of soft tissue/bony masses
- Fasciotomy and fasciectomy
- Fracture fixation
- Joint replacement, including minimally invasive techniques (excludes hip resurfacing)
- Ligament reconstruction
- Management of infections and inflammations of bones, joints, and tendon sheaths
- Muscle and tendon repair
- Open reduction and internal/external fixation of fractures and dislocations of the skeleton
- Reconstruction of nonspinal congenital musculoskeletal anomalies
- Treatment of cartilage injuries (e.g., autologous chondrocyte implantation [ACI] and osteoarticular transfer system [OATS])
- Treatment of trauma

➤ Shoulders and elbows
- Amputation surgery, including immediate prosthetic fitting in the operating room
- Arthrocentesis, diagnostic bone graphs, and allographs
  — Arthroscopy
- Joint replacement ([includes/excludes] minimally invasive techniques)
- Closed reduction of fractures and dislocations
- Muscle and tendon repair
- Open reduction and internal/external fixation of fractures and dislocations
- Debridement of soft tissue
- Excision of soft tissue/bony masses
- Fasciotomy and fasciectomy, and dislocations

➤ Foot and ankle
- Amputation surgery, including immediate prosthetic fitting in the operating room
- Arthroscopy
- Treatment of trauma
- Joint replacement ([includes/excludes] minimally invasive techniques)
- Closed reduction of fractures and dislocations
- Muscle and tendon repair
- Open reduction and internal/external fixation of fractures and dislocations
- Debridement of soft tissue
- Excision of soft tissue/bony masses
- Fasciotomy and fasciectomy
- Treatment of cartilage injuries (e.g., ACI and OATS)

➤ Hand
- Arthroplasty of large and small joints, wrist, or hand, including implants
- Amputation surgery, including immediate prosthetic fitting in the operating room
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- Arthrocentesis
- Diagnostic bone graphing and allographs
- Nerve decompression
- Fasciotomy and fasciectomy
- Fracture fixation with compression plates or wires
- Nerve graft
- Neurorrhaphy
- Closed reductions of fractures and dislocations
- Removal of soft tissue mass, ganglion on the palm or wrist, flexor sheath, etc.
- Repair of lacerations
- Repair of rheumatoid arthritis deformity

➤ Skin grafts
- Tendon reconstruction (free graft, staged)
- Tendon release, repair, and fixation
- Tendon transfers
- Treatment of infections
- Open reduction and internal/external fixation of fractures and dislocations
- Treatment of trauma

➤ Spine
- Assessment of the neurologic function of the spinal cord and nerve roots
- Interpretation of imaging studies of the spine
- Management of traumatic, congenital, developmental, infectious, metabolic, degenerative, and rheumatologic disorders of the spine
- Treatment of extensive trauma
- Open reduction and internal/external fixation of fractures and dislocations of the skeleton
- Closed reduction of fractures and dislocations

➤ Musculoskeletal oncology
- Detection of tumors through various imaging techniques, including x-ray, MRI, and bone scan procedures
- Tumor resection with local treatment
- Tumor resection with major limb reconstruction or amputation
- Biopsy and excision of tumors involving bone and adjacent soft tissues

**Special noncore privileges in orthopedic surgery**

If desired, noncore privileges are requested individually in addition to requesting the core. Each individual requesting noncore privileges must meet the specific threshold criteria governing the exercise of the privilege requested, including training, required previous experience, and maintenance of clinical competence. Noncore privileges include:

➤ Use of laser
➤ Hip resurfacing
➤ Percutaneous lumbar discectomy
➤ Percutaneous vertebroplasty
➤ Balloon kyphoplasty
➤ Lumbar disc arthroplasty
➤ Cervical disc arthroplasty
➤ Spinal cord simulation
➤ Growth disturbances such as injuries involving plates with a high percentage of growth arrest, growth inequality, epiphysiodesis, stapling, or bone shortening or lengthening procedures
➤ Administration of sedation and analgesia

Reappointment

Reappointment should be based on unbiased, objective results of care according to a hospital’s quality assurance mechanism.

To be eligible to renew core privileges in orthopedic surgery, applicants must demonstrate competence and an adequate volume of experience ([n] procedures for trauma and fractures of the hips and knees, [n] of the shoulders and elbows, [n] of the feet and ankles, [n] of the spine, [n] of the hand, and [n] musculoskeletal oncology procedures) with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current physical and mental ability to perform privileges requested it required of all applicants for renewal of privileges.

In addition, continuing education related to orthopedic surgery should be required.

For more information

Accreditation Council for Graduate Medical Education
515 North State Street, Suite 2000
Chicago, IL 60654
Telephone: 312-755-5000
Fax: 312-755-7498
Website: www.acgme.org

American Academy of Orthopaedic Surgeons
6300 North River Road
Rosemont, IL 60018
Telephone: 847-823-7186
Fax: 847-823-8125
Website: www.aaos.org
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American Board of Orthopaedic Surgery
400 Silver Cedar Court
Chapel Hill, NC 27514
Telephone: 919-929-7103
Fax: 919-942-8988
Website: www.abos.org

American Orthopaedic Association
6300 North River Road, Suite 505
Rosemont, IL 60018
Telephone: 847-318-7330
Fax: 847-318-7339
Website: www.aoassn.org

American Osteopathic Association
142 E. Ontario Street
Chicago, IL 60611-2864
Telephone: 800-621-1773 or 312-202-8000
Fax: 312-202-8200
Website: www.osteopathic.org

American Osteopathic Board of Orthopedic Surgery
800 Military Street, Suite 307
Port Huron, MI 48060
Telephone: 877-982-6267
Fax: 810-984-2530
Website: www.aobos.org

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
Telephone: 877-267-2323
Website: www.cms.gov

DNV Healthcare, Inc.
400 Techne Center Drive, Suite 350
Milford, OH 45150
Telephone: 513-947-8343
Website: www.dnvaccreditation.org
Orthopedic surgery

Healthcare Facilities Accreditation Program
142 E. Ontario Street
Chicago, IL 60611
Telephone: 312-202-8258
Website: www.hfap.org

The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
Telephone: 630-792-5000
Fax: 630-792-5005
Website: www.jointcommission.org

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