Oculofacial plastic and reconstructive surgery

Background

Oculofacial plastic and reconstructive surgery (OPRS) is a very specialized form of ophthalmology that focuses on the face, eyelids, brow, orbital bones, tear duct system, and nose. During a two-year fellowship, surgeons are trained in aesthetic and reconstructive facial surgery.

Oculofacial plastic surgery encompasses the management of deformities and abnormalities of the eyelids, lacrimal (tear) system, orbit (the bony cavity surrounding the eye), and surrounding areas of the face and neck. Reconstructive surgery can be cosmetic, can treat problems that interfere with vision, and can improve health and alleviate pain, as in the removal of tumors.

OPRS in itself is not a board-recognized subspecialty, but rather a narrowly focused area of training. The American Board of Ophthalmology (ABO) does not recognize the subspecialty of OPRS, but the training for ophthalmology should best prepare a physician for additional training in the specialized area of OPRS. The American Osteopathic Boards of Ophthalmology and Otolaryngology (AOBOO) awards certification in the subspecialty of otolaryngology/facial plastic surgery. Otolaryngology/facial plastic surgery requires a minimum of three to four years of residency training approved by the American Osteopathic Association (AOA).

The American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS), which is not a medical board, approves certain two-year fellowship programs in OPRS. ABO certification is required for membership in the ASOPRS.

For more information, please see Clinical Privilege White Paper, Ophthalmology—practice area 148.

Involved specialties

Oculofacial plastic and reconstructive surgeons, otolaryngologists, head and neck surgeons, ophthalmologists
Positions of specialty boards

**ABO**

To become board certified in ophthalmology by the ABO, candidates must spend at least one clinical year post-medical school in a program accredited by the Accreditation Council for Graduate Medical Education (ACGME) or by the Royal College of Physicians and Surgeons of Canada. During this training, the resident should be responsible for patient care in fields such as internal medicine, neurology, pediatrics, surgery, family practice, or emergency medicine. As a minimum, six months of this year must consist of a broad experience in direct patient care. Following this initial year of training, residents must complete a 36-month residency training program in ophthalmology.

As of 2012, the ABO requires successful completion of board certification requirements within seven years of residency graduation. All candidates for board certification who complete residency in 2012 and beyond must successfully complete the written and oral examinations within seven years of finishing residency. All candidates who completed residency prior to 2012 must successfully complete the written and oral examinations within seven years of the 2012 implementation of the new policy (by December 31, 2018).

**AOBOO**

Candidates for certification in otolaryngology/facial plastic surgery through the AOBOO must meet the following requirements:

- Graduate from an AOA-accredited college of osteopathic medicine.
- Be licensed to practice in the state or territory where his or her practice is conducted.
- Be a member in good standing of the AOA or the Canadian Osteopathic Association throughout the certification process.
- Satisfactorily complete a one-year AOA-approved traditional rotating internship. In otolaryngology/facial plastic surgery, when applicable, a one-year specialty track internship (which includes general surgery) is acceptable.
- Satisfactorily complete an AOA-approved residency training program in one of the specialties under the jurisdiction of the AOBOO after the required year of internship. The training program must encompass all aspects of the particular specialty, include adequate training in the basic medical sciences, and place emphasis on the osteopathic principles as related to the specialty.

Candidates pursuing certification in otolaryngology/facial plastic surgery must complete a minimum of three years of AOA-approved residency training if training was begun prior to July 1, 1986. A period of four years of
AOA-approved residency training in otolaryngology/facial plastic surgery is required if training was begun on or after July 1, 1986. One year of general surgery is required prior to the four-year residency, except if the candidate completes a one-year specialty track internship, as noted above.

Following satisfactory compliance with the prescribed requirements for examination, the candidate is required to pass appropriate examinations planned to evaluate an understanding of the scientific bases of the problems involved in ophthalmology, otolaryngology, and facial plastic surgery; familiarity with the current advances in these specialties; and possession of sound judgment and high degree of skill in the diagnostic and therapeutic procedures involved in the practice of these specialties. Candidates for examination for certification are required to file an application that shall set forth their qualifications for examination.

All candidates for certification will be issued time-dated certificates for a 10-year period, after which the diplomate must apply for recertification.

Positions of societies, academies, colleges, and associations

**ASOPRS**

The ASOPRS, which credentials a select number of fellowship training programs, only accepts members who are certified by the ABO. The length of the educational program is 24 months of full-time education, according to the *ASOPRS Program Requirements for Fellowship Education in Oculofacial Plastic Surgery*.

Following training, fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Fellows must directly evaluate and provide diagnosis and treatment plans in the care of a minimum of 1,200 patients per year during the course of training. These patients must have oculofacial plastic surgery–related problems. The fellow must be able to demonstrate that the history and examination were accurate and appropriate, that the use of laboratory and imaging tests was directed by the history and physical examination, and that the differential diagnosis and management were appropriate. Fellows should teach oculofacial plastic surgery to ophthalmology residents.

The fellowship program should provide training experience in the following specific areas:

- Anatomy and physiology of the orbit, eyelids, lacrimal system, nose, sinuses, and head and neck as it relates to the orbits and adnexa
- Orbit (including common orbital problems of children and adults)
- Eyelid, including congenital syndromes, inflammation, trauma, ectropion, entropion, trichiasis, blepharoptosis, eyelid retraction, dermatochalasis,
blepharochalasis, eyelid tumors, blepharospasm, facial nerve palsy, eyebrow, mid-face and lower face function and aesthetics, and histology and pathology of the facial skin, including medical and surgical management of these conditions

➤ Lacrimal system, including congenital tearing, acquired tearing, and trauma
➤ Ocular surface pathology, including cicatricial processes affecting the bulbar and palpebral conjunctiva, management of corneal and conjunctival exposure, and relationship of the lids, mid-face, and brow to ocular exposure
➤ Regional anatomy, including frequently used graft donor sites such as cranial bone, ear, nose, temporal area, mouth and neck, abdomen, buttocks, legs, supraclavicular area, and arm
➤ Fundamentals of ocular and orbital anatomy, chemistry, physiology, microbiology, immunology, and wound healing
➤ Experience in neuroradiology for radiologic interpretation of images (CT, MRI, MRA, arteriography, ultrasound)
➤ Ocular pathology to interpret ocular and periocular pathology and dermatopathology
➤ Diagnostic and therapeutic procedures with comprehensive examination of the eyelids and periorbital region (should be documented)
➤ Examination of the lacrimal system; nasal exam with speculum and endoscope
➤ Eyebrow and face examination: assessing the eyebrow position for brow ptosis, paralysis, and determining its relation to upper eyelid dermatochalasis; assessing facial paralysis; and evaluating the effects of mid-face cicatricial, paralytic, and involutional changes on lower eyelid position
➤ Examination and measurement of orbital structures and functions
➤ Understanding and interpreting imaging techniques
➤ The principles of plain films, CT, MRI, and ultrasound imaging relating to the head and neck with particular emphasis on the orbit
➤ Type of scan/imaging to order, given the clinical setting, and ability to read the film or scan
➤ Skills in the use of information technology for study of reference material, including electronic searching and retrieval of relevant articles, monographs, and abstracts

Fellows are expected to maintain a surgical log including surgeon (primary surgeon) and assistant (assisting and/or observing surgeon) cases, and must perform a minimum of 300 cases plus 150 minor office procedures, which include biopsies and incision/curettage.

Fellows must be competent in the following required skills and procedures:
➤ Enucleation, evisceration, exenteration, and secondary implants of the orbit
➤ Orbitotomy for exploration, biopsy, and tumor removal using anterior, lateral, medial, and superior approaches and orbital reconstruction
➤ Fracture repair of bones involving the periorbital region and orbit
➤ Eyelid retraction repair
➤ Blepharoptosis repair
Oculofacial plastic and reconstructive surgery

➤ Ectropion and entropion repair
➤ Blepharoplasty (upper and lower eyelids, functional and aesthetic)
➤ Eyelid reconstruction (following congenital defects, trauma, or tumor excision)
➤ Repair of trichiasis (cryoablation, lid split and excision, mucous membrane graft)
➤ Conjunctivoplasty
➤ Trauma and laceration repairs
➤ Tissue transfer, grafts, and flaps
➤ Dacryocystorhinostomy and other lacrimal procedures
➤ Excision of tumors (benign and malignant) involving the periorbital and adjacent regions
➤ Facial flaps, including temporal, mid-face, and lower face/neck for functional and aesthetic conditions related to the management of periorbital processes; rhytidectomy, including the periorbital and adjacent areas
➤ Management of upper face and brow conditions, including brow ptosis repair
➤ Turbinectomy and nasal surgery as related to the management of lacrimal and periorbital processes
➤ Nasal endoscopy as related to the management of lacrimal and periorbital processes
➤ Sinus surgery and endoscopy as related to periorbital and lacrimal processes
➤ Use of neuromodulators (botulinum toxin), dermal fillers, other technologies (e.g., laser), and chemical/pharmaceutical agents for the management of contour and skin quality abnormalities (functional and aesthetic)

Additionally, ASOPRS requires fellows to actively participate in the preoperative and postoperative management of surgical cases for which they are part of the surgical team. They must learn the fundamentals of cosmetic surgery and its complications with emphasis on brows and mid-face as well as alloplastic inserts, and must learn the team approach to orbital and periorbital trauma.

Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, as well as the application of this knowledge to patient care. Participation in a minimum of 80 hours of didactic instruction, including seminars, lectures, approved basic science courses, and hands-on skilled courses, of which at least 40 hours will be intramural, is required. The ASOPRS practice guidelines outline specific attendance requirements as well.

AAO

The American Academy of Ophthalmology (AAO), a national membership association, recognizes ophthalmic plastic surgery as a subspecialty of ophthalmology. According to the AAO, ophthalmic plastic surgery combines orbital and periocular surgery with facial plastic surgery and includes the clinical practice of aesthetic, plastic, and reconstructive surgery of the face, orbit, eyelid, and lacrimal system. Surgeons in this subspecialty perform eyelid surgery, facial plastic surgery, orbital surgery, and lacrimal surgery.
Oculofacial plastic and reconstructive surgery

Practice area 419

The AAO does not publish training requirements or guidelines specific to this subspecialty. However, the AAO does note that every ophthalmologist spends a minimum of three years of residency training in the specialty, following four years of medical school and one year of internship. After residency, physicians opt for an additional one to two years of training in a subspecialty or specific area of eye care.

AOA

According to the AOA’s Basic Standards for Residency Training in Otolaryngology/Facial Plastic Surgery, the residency training program in otolaryngology/facial plastic surgery must be 60 months in duration.

Residents must participate in structured educational activities throughout their training program. Each resident is also required to participate in otolaryngology/facial plastic surgery board review, either in the form of an ongoing program or by the program sponsoring the resident’s attendance at an otolaryngology/facial plastic surgery board review course. By the completion of the residency program, each resident must have completed a formal basic science course (at minimum 100 hours) and demonstrate competency in the basic sciences and medical and surgical knowledge of the following areas: morphology, physiology, pharmacology, pathology, microbiology, biochemistry, genetics, and immunology relevant to the head and neck; the upper respiratory and upper alimentary systems; the communication sciences, including knowledge of audiology and speech-language pathology; the chemical senses and allergy, endocrinology, and neurology as they relate to the head and neck; and voice sciences as they relate to laryngology.

In regard to patient care, the resident must have the following training and experiences:

➤ Comprehensive histories and physicals, including structural examinations, with emphasis on the head and neck and related systems
➤ Surgical procedures, including the following:
  − Head and neck (salivary glands, nose and maxilla, lips, oral cavity, neck, larynx)
  − Otologic
  − Facial plastic and reconstructive
  − Congenital anomalies
  − Laser
  − Endoscopy, to include indications, contraindications, complications, limitations, and evidence of competent performance
➤ Interpretation, indications, contraindications, and complications of audiologic, vestibular, and vocal function testing, biopsy and fine needle aspiration techniques, and other clinical and laboratory procedures related to the diagnosis of diseases and disorders of the upper airway and digestive tract and the head and neck
Management of congenital, degenerative, idiopathic, infectious, inflammatory, toxic, allergic, immunologic, vascular, metabolic, endocrine, neoplastic, foreign body, and traumatic states; airway management; resuscitation; local/regional anesthesia; sedation; and universal precaution techniques, including indications, contraindications, complications, limitations, and evidence of competent performance

Operative intervention, and preoperative and postoperative care of the following major categories:
- General otolaryngology, including pediatric otolaryngology, rhinology, bronchoesophagology, and laryngology
- Head and neck oncologic surgery
- Facial plastic and reconstructive surgery of the head and neck
- Otology and neurotology

Competent performance of habilitation and rehabilitation techniques and procedures in the areas of respiration, deglutition, chemoreception, balance, speech, and auditory measures such as hearing aids and implantable devices

Diagnosis and application of therapeutic techniques involving endoscopy of the upper airway and digestive tract, including rhinoscopy, laryngoscopy, esophagoscopy, and bronchoscopy, as well as the associated application of stroboscopes, lasers, mechanical debriders, computer-assisted guidance devices, and nerve integrity monitors

Therapeutic radiology and the interpretation of x-rays, CT scan, MRI, and other imaging modalities of the head and neck and thorax, including temporal bone, skull, nose, paranasal sinuses, salivary glands, thyroid gland, larynx, neck, lungs, and esophagus

Familiarity with state-of-the-art advances and emerging technology in otolaryngology and head and neck surgery

With regard to surgical procedures, residents must have major technical and patient care responsibilities in surgery (including laser surgery). Each resident must perform, as primary surgeon, at least the following required number of operative procedures prior to graduation:
- Head and neck: 25 major per year
- Otology: 20 major per year
- Plastic and reconstructive: 35 major per year
- Endoscopic sinus surgery: 25 major per year
- Congenital anomalies: 3 major per year
- Laser pertaining to all categories: 10 per year

The first year of osteopathic graduate medical education (OGME1) training must contain the following elements:
- Four months hospital-based general surgery
- One month medical pediatrics
- One month anesthesia
- One month ICU
- One month emergency room
Oculofacial plastic and reconstructive surgery

Practice area 419

➤ One month surgical subspecialty (neurological, vascular, maxillofacial, plastic, cardiovascular, general)
➤ One month medical subspecialty (pulmonary, neurology, family medicine, gastroenterology, dermatology, internal medicine, ophthalmology)
➤ Two months elective (from surgical subspecialty or medical subspecialty lists above)

During training years OGME-2 through OGME-5, the resident must have the following rotations:
➤ Otology
➤ Rhinology
➤ Laryngology
➤ Head and neck
➤ Facial plastic surgery
➤ Pediatric otolaryngology
➤ Otolaryngic allergy

According to the AOA, residents of the program must be members of the American Osteopathic Colleges of Ophthalmology and Otolaryngology–Head and Neck Surgery (AOCOO-HNS) and should submit an annual resident report to the AOCOO-HNS within 30 days of completion of each training year. Residents are required to attend a minimum of 70% of all meetings and participate in hospital committee meetings as directed by the program director, and must participate each year in the annual resident in-service examination. Residents must attend the AOCOO-HNS Annual Clinical Assembly or another AOCOO-HNS continuing education program once during the training program. The AOA also requires that residents maintain certification in advanced cardiac life support throughout the residency.

ACGME

According to the ACGME Program Requirements for Graduate Medical Education in Ophthalmic Plastic and Reconstructive Surgery, the educational program must be 24 months in length. With regard to patient care, fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Fellows must directly evaluate, and provide diagnosis and treatment plans, for a minimum of 1,200 patient encounters per year during the course of education. These patients must have ophthalmic plastic and reconstructive surgery–related problems. The fellow must be able to demonstrate that the history and examination were accurate and appropriate, the use of laboratory and imaging tests was directed by the history and physical examination, and that the differential diagnosis and management were appropriate. Fellows should also demonstrate proficiency in the following procedures:
➤ Enucleation, evisceration, exenteration, and secondary implants of the orbit
➤ Orbitotomy for exploration, biopsy, and tumor removal; anterior, lateral, medial and superior and orbital reconstruction for periorbital anomalies
➤ Eyelid retraction repair
➤ Blepharoptosis repair
➤ Ectropion and entropion repair
➤ Blepharoplasty (upper and lower eyelids, functional and aesthetic)
➤ Eyelid reconstruction (following congenital defects, trauma, or tumor excision)
➤ Repair or treatment of trichiasis (lid split, mucous membrane graft)
➤ Conjunctivoplasty
➤ Trauma and laceration repairs
➤ Rhytidectomy limited to periorbital tissues
➤ Dacryocystorhinostomy and other lacrimal procedures
➤ Excision of tumors (benign and malignant) involving the periobital and adjacent regions
➤ Facial flaps and grafts related to the management of periorbital processes
➤ Management of upper face and brow conditions (e.g., brow ptosis repair)

Fellows are expected to participate in planned rotations in procedural dermatology, otolaryngology, neuro-ophthalmology, and plastic surgery in order to understand how other specialties approach the management of diseases of the head and neck that directly affect the management of ocular and periorbital disease, with a set of measurable goals and objectives to be attained at the end of each rotation. Fellows must maintain a surgical log including surgeon (primary surgeon) and assistant (assisting and/or observing surgeon) cases, and must document a minimum number of 300 operative procedures in an operating room or equivalent facility, plus 150 minor office-based procedures, such as biopsies and incision/curettage.

ACGME requires residents to document in the case log system a sufficient number and distribution of complex cases for surgeon (fellow as the primary surgeon) and assistant (fellow as the first assistant), as determined by the review committee, for the achievement of adequate operative skill and surgical judgment, as well as actively participate in the preoperative and postoperative management of surgical cases in which they are part of the surgical team.

Fellows must have instruction in the following specific areas:
➤ Anatomy and physiology of the orbit, eyelids, lacrimal system, nose, sinuses, and head and neck as they relate to the orbits and adnexa
➤ Common orbital problems of children, including congenital anomalies, cellulitis, benign and malignant tumors, and orbital inflammations
➤ Common orbital disorders of adults, including orbital cellulitis, thyroid orbitopathy and pseudotumor, vasculitis, congenital tumors, vascular tumors, neural tumors, lacrimal gland tumors, fibro-osseous tumors, histiocytic diseases, lymphoid tumors, metastatic tumors, trauma, anophthalmic socket problems, and skull base disease
➤ Eyelid, including congenital syndromes, inflammation, trauma, ectropion, entropion, trichiasis, blepharoptosis, eyelid retraction, dermatochalasis, blepharochalasis, eyelid tumors, blepharospasm, facial nerve palsy, eyebrow, mid-face and lower face function, and aesthetics
➤ Lacrimal system, including congenital tearing, acquired tearing, and trauma
➤ Ocular surface pathology, including cicatricial processes affecting the bulbar and palpebral conjunctiva, management of corneal and conjunctival exposure, and relationship of the lids, mid-face, and brow to ocular exposure
➤ Regional anatomy, including graft sites frequently used such as cranial bone, ear, nose, temporal area, mouth and neck, abdomen, buttocks, legs, supraclavicular area, and arm
➤ Fundamentals of ocular and orbital anatomy, chemistry, physiology, microbiology, immunology, and wound healing
➤ Histology and pathology to interpret ocular, cutaneous, and periocular pathology and dermatopathology (this should include 10 hours of pathology slide review with clinical correlation)
➤ Diagnostic and therapeutic procedures with comprehensive examination of the eyelids and periorbital region
➤ Examination of the lacrimal system, and nasal exam with speculum and endoscope
➤ Examination of the eyebrow and face, including assessment of the eyebrow position for brow ptosis, paralysis, and its relation to upper eyelid dermatochalasis, for facial paralysis and evaluation of the effects of mid-face cicatricial, paralytic, and involutional changes on lower eyelid position
➤ Examination and measurement of orbital structures and functions
➤ Principles of plain films, CT, MRI, and ultrasound imaging relating to the head and neck with particular emphasis on the orbit
➤ The use of information technology for study of reference material, including electronic searching and retrieval of relevant articles, monographs, and abstracts

Fellows must participate in one orbital dissection during their 24-month program, learn the fundamentals of cosmetic surgery and its complications with emphasis on brows and mid-face, as well as alloplastic inserts, and learn the team approach to orbital and periorbital trauma.

**CMS**

CMS has no formal position concerning the delineation of privileges for OPRS. 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 OPRS. 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 OPRS. 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 OPRS. 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 OPRS. 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 OPRS**

Basic education: MD or DO

Minimal formal training: Successful completion of an ACGME- or AOA-accredited residency in ophthalmology and/or current certification or active participation in the examination process (with achievement of certification within [n] years) leading to certification in ophthalmology by the ABO, followed by successful completion of an ASOPRS-approved fellowship in OPRS.

Required previous experience: Successful performance of at least 150 OPRS procedures during the previous 12 months, reflective of the scope of privileges requested, or demonstrate successful completion of an ACGME- or AOA-accredited residency, clinical fellowship, or research in a clinical setting within the previous 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.

**Reappointment**

Reappointment should be based on unbiased, objective results of care according to a hospital’s quality assurance mechanism. To be eligible to renew privileges in OPRS, the applicant must have current demonstrated competence.
and an adequate volume of experience (300 OPRS 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. In addition, continuing medical education related to OPRS 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
Website: www.acgme.org

American Academy of Ophthalmology
655 Beach Street
San Francisco, CA 94109
Telephone: 415-561-8500
Fax: 415-561-8533
Website: www.aao.org

American Board of Medical Specialties
222 North LaSalle Street, Suite 1500
Chicago, IL 60601
Telephone: 312-463-2600
Website: www.abim.org

American Board of Ophthalmology
111 Presidential Boulevard, Suite 241
Bala Cynwyd, PA 19004-1075
Telephone: 610-664-1175
Website: www.abop.org

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

American Osteopathic Boards of Ophthalmology and Otolaryngology
Huber Heights, OH 45424
P.O. Box 24810
Telephone: 800-575-2145
Website: www.aoboo.org
Oculofacial plastic and reconstructive surgery
Practice area 419

American Society of Ophthalmic Plastic & Reconstructive Surgery
5841 Cedar Lake Road
Minneapolis, MN 55416
Website: www.asoprs.org

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
Telephone: 800-633-4227
Website: www.cms.gov

DNV Healthcare, Inc.
1400 Ravello Drive
Katy, TX 77440
Telephone: 281-396-1000
Website: www.dnvaccreditation.com

Healthcare Facilities Accreditation Program
142 East 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
Website: www.jointcommission.org

The information contained in this document is general. It has been designed and is intended for use by hospitals and their credentials committees in developing their own local approaches and policies for various credentialing issues. This information, including the materials, opinions, and draft criteria set forth herein, should not be adopted for use without careful consideration, discussion, additional research by physicians and counsel in local settings, and adaptation to local needs. The Credentialing Resource Center does not provide legal or clinical advice; for such advice, the counsel of competent individuals in these fields must be obtained.

Reproduction in any form outside the recipient's institution is forbidden without prior written permission. Copyright © 2012 HCPro, Inc., Danvers, MA 01923.