CLINICAL PRIVILEGE WHITE PAPER

Sinus endoscopy

Background

Sinus endoscopy, also referred to as endoscopic sinus surgery or sinoscopy, is used to remove blockages, swelling, and other conditions that hinder the patient’s ability to breathe freely, such as:

➤ Sinusitis
➤ Septal deviations or turbinate hypertrophy
➤ Nasal polyps

Endoscopic sinus procedures are generally performed under general anesthesia, according to the Johns Hopkins Sinus Center.

Physicians performing sinus endoscopy procedures insert a tiny camera called an endoscope into the nostril, enabling them to visualize the sinuses. This allows them to both diagnose sinus conditions and perform surgical procedures without making external incisions, according to the American Rhinologic Society (ARS).

Previously, when a patient needed sinus surgery, the surgeon had to make incisions in the patient’s face or mouth, which left scars and required a long recovery period, according to the ARS. Conversely, the society states, endoscopic procedures greatly reduce the pain and recovery time associated with surgeries, and require much less nasal packing.

Involved specialties

Otolaryngologists, oral and maxillofacial surgeons, and plastic surgeons

Positions of specialty boards

ABOto

The American Board of Otolaryngology (ABOto) offers board certification in otolaryngology.

To become certified, an individual must graduate from medical school and complete a five-year residency in otolaryngology. According to the ABOto’s Booklet of Information, this training should include a minimum of nine months of basic surgical, emergency medicine, critical care, and anesthesia training within the first year, and should include a final year of senior experience. Upon successful
completion of training, the candidate can apply to take the two-part certification exam. The individual must pass both parts to become board certified. Beginning in 2002, the ABOto required diplomates to participate in maintenance of certification to stay up to date in the specialty.

The ABOto does not publish guidelines specific to sinus endoscopy.

**AOBOO-HNS**


Candidates must meet the following requirements:

➤ Graduation from an American Osteopathic Association (AOA)–accredited college of osteopathic medicine.
➤ Unrestricted license to practice in the state or territory where the candidate’s practice is conducted.
➤ Membership in good standing of the AOA or the Canadian Osteopathic Association throughout the certification process.
➤ Satisfactory completion of a one-year AOA-approved traditional rotating internship prior to entering the residency program.
➤ Satisfactory completion of an AOA-approved residency training program in one of the specialties under the jurisdiction of the AOBOO-HNS after the required year of internship. The training program must encompass all aspects of the particular specialty, including adequate training in the basic medical sciences, with emphasis on the osteopathic principles as related to the specialty.

In addition to meeting the training requirements, candidates must also pass the appropriate examinations.

The AOBOO-HNS does not publish guidelines specific to sinus endoscopy.

**ABOMS**

The American Board of Oral and Maxillofacial Surgery (ABOMS) offers board certification in oral and maxillofacial surgery. To gain certification, the candidate must demonstrate successful completion of training in an accredited residency program, as well as post-training experience and successful completion of computer-administered and oral examinations on the entire scope of the specialty.

The board does not include standards specific to sinus endoscopy.
The American Board of Plastic Surgery (ABPS) offers two different educational models for board certification in plastic surgery, the independent model or the integrated model. Plastic surgery programs can also incorporate both models into one training program. Candidates for any of the programs must meet set requirements, including:

➤ Basic surgical science knowledge and experience with basic principles of surgery
➤ Advanced knowledge of specific plastic surgery techniques

In the independent model, residents complete prerequisite training outside of their plastic surgery residency. In the integrated model, residents complete training as part of the same program. A combined or coordinated program allows residents to complete the prerequisite for the general surgery training program at the same institution as the plastic surgery program. However, the combined program will not continue beyond the entry date of July 1, 2014.

According to the ABPS, training should allow the individual to grow and eventually assume complete surgical care responsibilities. Training in plastic surgery must also cover the entire spectrum of plastic surgery. It should include experience in the following areas:

➤ Congenital defects of the head and neck, including clefts of the lip and palate, and craniofacial surgery
➤ Head and neck surgery, including neoplasms of the head, neck, and oropharynx
➤ Craniomaxillofacial trauma, including fractures
➤ Aesthetic (cosmetic) surgery of the head and neck, trunk, and extremities
➤ Plastic surgery of the breast
➤ Surgery of the hand/upper extremity
➤ Plastic surgery of the lower extremities
➤ Plastic surgery of the trunk and genitalia
➤ Burn reconstruction
➤ Microsurgical techniques applicable to plastic surgery
➤ Reconstruction by tissue transfer, including flaps and grafts
➤ Surgery of benign and malignant lesions of the skin and soft tissues

The six years of integrated program training should include appropriate plastic surgery clinical experiences, including:

➤ Alimentary tract surgery
➤ Abdominal surgery
➤ Breast surgery
➤ Emergency medicine
➤ Pediatric surgery
➤ Surgical critical care
➤ Surgical oncology and transplantation
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➤ Trauma management
➤ Vascular surgery

The ABPS does not publish standards or requirements directly related to sinus endoscopy.

**AOBS**

The American Osteopathic Board of Surgery (AOBS) accepts certification for examination for osteopathic physicians who are specializing in plastic and reconstructive surgery.

For plastic and reconstructive surgery, the candidate must meet the following training requirements:

➤ Three years of training in general surgery followed by two years of training in plastic and reconstructive surgery
➤ Completion of an AOA-approved residency program in orthopedic surgery
➤ Completion of an AOA-approved residency in otolaryngology/facial plastic surgery

The AOBS does not include publish standards or requirements specific to sinus endoscopy.

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

**AAOMS**

The American Association of Oral and Maxillofacial Surgeons (AAOMS) represents more than 9,000 oral and maxillofacial surgeons in the United States. In order to become a member, candidates must meet rigorous continuing education requirements and submit to periodic office examinations, assuring the public that all office procedures and personnel meet stringent national standards.

The AAOMS does not publish standards specific to sinus endoscopy.

**ACGME**

The Accreditation Council for Graduate Medical Education (ACGME) publishes *Program Requirements for Graduate Medical Education in Otolaryngology*. According to these requirements, education in this area should give trainees core knowledge, skills, and understanding of the basic medical sciences relevant to the head, neck, and upper respiratory/upper alimentary systems in addition to other skills.

Training should also include clinical aspects of diagnosis, medical and/or surgical therapy, and the prevention of and rehabilitation from diseases, neoplasms, deformities, disorders, and/or injuries of the ears, upper respiratory and upper
alimentary systems, the face, the jaws, and other head and neck systems; head and neck oncology; and facial plastic and reconstructive surgery.

Trainees should be able to diagnose and use therapies involving endoscopy of the upper aerodigestive tract, including rhinoscopy, laryngoscopy, esophagoscopy, and bronchoscopy, as well as the associated application of stroboscopes, lasers, mechanical debriders, and computer-assisted guidance devices.

Individuals should have experience with state-of-the-art advances and emerging technology in otolaryngology and head-and-neck surgery and should perform a sufficient number and variety of surgical procedures to ensure education in the entire scope of the specialty.

The ACGME graduate education requirements in otolaryngology do not include standards specific to sinus endoscopy.

According to the ACGME’s Program Requirements for Graduate Medical Education in Plastic Surgery, residency training in plastic surgery must include clinical experiences in a number of areas. Plastic surgery fellows are strongly suggested to have clinical experience in oral and maxillofacial surgery. The ACGME graduate medical education guidelines in plastic surgery do not include standards specific to sinus endoscopy.

AOA

The AOA publishes Basic Standards for Residency Training in Otolaryngology/Facial Plastic Surgery. Under the standards, the residency training program in otolaryngology/facial plastic surgery must be 60 months long and the resident must have the following training and experience:

- Comprehensive histories and physicals, including structural examinations, with emphasis on the head and neck and related systems
- Surgical procedures including:
  - Head and neck (salivary glands, nose and maxilla, lips, oral cavity, neck, larynx)
  - Otologic
  - Facial plastic and reconstructive
  - Congenital anomalies
  - Laser
  - Endoscopy (to include, at minimum, indications; contraindications; complications; limitations; and evidence of competent performance)
- Interpretation, indications, contraindications, and complications of audioligic, 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, and sedation; and universal precaution techniques (to include, at minimum, 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

➤ Competently performing habilitation and rehabilitation techniques and procedures in the areas of respiration, deglutition, chemoreception, balance, and speech, as well as auditory measures such as hearing aids and implantable devices

➤ Diagnosing and applying 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

➤ State-of-the-art advances and emerging technology in otolaryngology and head-and-neck surgery

➤ Operative intervention, and preoperative and postoperative care of the following major categories:
  – General otolaryngology, including pediatric otolaryngology, rhinology, bronchoesophagology and laryngology

The AOA does not publish standards specific to sinus endoscopy.

Position of subject matter experts

Martin J. Citardi, MD
Houston

Martin J. Citardi, MD, professor and chairman of the Department of Otorhinolaryngology-Head & Neck Surgery at the University of Texas Medical School at Houston, says that sinus endoscopy encompasses a family of procedure codes, including in-office diagnostic nasal endoscopy and a series of nasal surgery endoscopy codes related to chronic inflammatory disease of the sinuses.

According to Dr. Citardi, the physicians who perform these procedures are typically otolaryngologists and occasionally ocular plastic surgeons. Training for sinus endoscopy is part of otolaryngology training and is a key index procedure
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according to the ACGME.

The number of procedures performed during training is variable, based on the individual skills of the physician, says Dr. Citardi. Those who conduct the training should determine how many procedures an individual needs to perform to achieve competence based on his or her skill level.

Timothy Dettmer, MD
Mason City, Iowa

According to Timothy Dettmer, MD, president of the Iowa Academy of Otolaryngology and private practice physician at the Mason City (Iowa) Clinic, sinus endoscopy procedures are primarily performed by otolaryngologists.

In order to perform sinus endoscopy, a physician should have graduated from medical school and completed a residency in otolaryngology. Residency programs include sinus endoscopy training as part of the program, says Dr. Dettmer.

“There are numerous types of scopes available for sinus endoscopy procedures, but typically vendors don’t provide training or proctoring,” says Dr. Dettmer. “The procedures are typically learned on the job as a resident being supervised by the staff physician.”

When it comes to diagnostic sinus endoscopy training, physicians typically perform thousands of these procedures during their residency, which means most physicians are automatically very comfortable with them. But they would need to perform 30 or more surgical rigid nasal endoscopy procedures or other more complicated procedures to achieve competency, according to Dr. Dettmer. He adds that in order to maintain their skill, physicians should perform at least five of these procedures a year. “It’s not something they have to be doing every week,” he says.

In addition to having the knowledge and skill to perform endoscopic sinus procedures, physicians should also have a good grasp of basic otolaryngology skills so they are able to manage complications, such as ocular problems, and treat patients effectively.

Positions of accreditation bodies

CMS

CMS has no formal position concerning the delineation of privileges for sinus endoscopy. 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
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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
byleaws 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 indi-
vidually assessed.

CMS also requires that the organization have a process to ensure that practitio-
ners 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 rec-
ommends that an appraisal be conducted at least every 24 months. The purpose
of the periodic appraisal is to determine whether clinical privileges or member-
ship should be continued, discontinued, revised, or otherwise changed.

The Joint Commission

The Joint Commission has no formal position concerning the delineation of privi-
leges for sinus endoscopy. However, in its Comprehensive Accreditation Manual for
Hospitals, The Joint Commission states, “The hospital collects information regard-
ing each practitioner’s current license status, training, experience, competence,
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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 infor-
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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 sinus endoscopy. 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 sinus endoscopy. 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 termina-
tion 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 evalu-
ated 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 sinus endoscopy.

**Minimum threshold criteria for requesting privileges in sinus endoscopy**

**Basic education:** MD or DO

**Minimal formal training:** Successful completion of an ACGME- or AOA-
accredited residency in otolaryngology, oral and maxillofacial surgery, or plastic
surgery.

**Required current experience:** Demonstrated current competence and evidence
of the performance of at least five sinus endoscopy procedures in the past
12 months to determine competency based on outcomes, or completion of training
in 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.
Reappointment

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

Applicants must be able to demonstrate that they have maintained competence by showing evidence of the performance of at least 10 sinus endoscopy procedures in the past 24 months, based on results of ongoing professional practice evaluation or performance monitoring.

In addition, continuing education related to sinus endoscopy 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 Association of Oral and Maxillofacial Surgeons
9700 West Bryn Mawr Avenue
Rosemont, IL 60018-5701
Telephone: 847-678-6200
Website: www.aaoms.org

American Board of Oral and Maxillofacial Surgery
625 North Michigan Avenue, Suite 1820
Chicago, IL 60611-3177
Telephone: 312-642-0070
Website: www.aboms.org

American Board of Otolaryngology
5615 Kirby Drive, Suite 600
Houston, TX 77005
Telephone: 713-850-0399
Website: www.aboto.org

American Board of Plastic Surgery
Seven Penn Center, Suite 400
1635 Market Street
Philadelphia, PA 19103-2204
Telephone: 215-587-9322
Website: www.abplsurf.org
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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 Board of Surgery
4764 Fishburg Road
Huber Heights, OH 45424
Telephone: 800-782-5355
Website: www.aobs.org

American Osteopathic Boards of Ophthalmology and Otolaryngology-Head and Neck Surgery
P.O. Box 24810
Huber Heights, OH 45424
Telephone: 800-575-2145
Website: www.osteopathic.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
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Mason City Clinic
250 S Crescent Drive
Mason City, IA 50401
Telephone: 641-494-5200
Website: www.mcclinic.com

University of Texas Medical School at Houston
6431 Fannin Street
Houston, TX 77030
Telephone: 713-500-4472
Fax: 713-500-5533
Website: www.uth.edu