Background

The American Podiatric Medical Association (APMA) defines podiatry as the medical practice area concerned with the diagnosis and treatment of conditions affecting the foot, ankle, and related structures of the leg. Within the field of podiatry, practitioners can focus on many different specialty areas, including surgery, sports medicine, biomechanics, geriatrics, pediatrics, orthopedics, or primary care.

A podiatrist is a doctor of podiatric medicine (DPM). DPMs receive medical education and training comparable to medical doctors, including four years of undergraduate education, four years of graduate education at one of eight accredited podiatric medical colleges, and two or three years of hospital residency training. The American Board of Podiatric Medicine (ABPM) is the certifying board for the specialty areas of podiatric orthopedics and primary podiatric medicine. The American Board of Podiatric Surgery (ABPS) is the certifying board for the specialty areas of foot surgery and reconstructive rearfoot/ankle (RRA) surgery.

Involved specialties

Podiatrists, podiatric surgeons

Positions of specialty boards

ABPM

To become certified in podiatric orthopedics and primary podiatric medicine through the ABPM, podiatrists must first achieve board qualification by:

- Completing residency training approved by the Council on Podiatric Medical Education (CPME)
- Submitting clinical activity logs demonstrating adequate diversity and volume of case participation during residency
- Passing the qualification examination
- Providing evidence of an active license to practice podiatry

Board-qualified status is granted for a period of five years. To obtain board certification, podiatrists must:

- Have achieved board qualified status with the ABPM
- Provide documentation of a minimum of 36 months of clinical experience and/or education, inclusive of residency training
• Successfully pass the case documentation process, which is a prerequisite for sitting for the certification examination
• Pass the certification examination

Beginning with the 2013 board certification examination, residents who have completed a minimum of 36 months of CPME-approved training are no longer required to submit case documentation as a prerequisite to the certification examination. Candidates with older residency types who meet the 36-month minimum may also be eligible. Candidates with 24 months of CPME-approved training are still required to submit case documentation and pass the case review process for admission to the certification examination.

**ABPS**

Upon completion of a four-year doctoral training program at a CPME-accredited podiatric medical school, residency training is required to qualify for ABPS certification. Candidates must complete a minimum of two years of residency training in a program approved by the CPME. One of the two years must be in a CPME-approved podiatric surgical residency.

In July 2011, the CPME implemented a single three-year residency—the podiatric medicine and surgery residency (PMSR). The PMSR replaced the two-year and three-year residencies in podiatric medicine and surgery.

Prior to 1991, the ABPS had a single certification track in foot and ankle surgery. Since then, it has had two certification tracks: one in foot surgery and the other in RRA surgery. Completion of a residency with the added credential in RRA surgery is required for pursuit of the RRA surgery certification pathway.

To become board-qualified in foot surgery through the ABPS, candidates must:
• Submit verified residency clinical logs through Podiatry Residency Resource documenting the minimum activity volumes and surgical diversity for foot surgery specified by CPME Document 320
• Pass Part I of the certification examination in foot surgery

Board-qualified status is valid for seven years. To obtain board certification in foot surgery, candidates must also:
• Submit a list of procedures through Podiatry Logging Service for Surgery demonstrating a diversity of surgical experience in foot surgery
• Gain approval by the ABPS Credentials Committee of complete foot surgery case documentation of procedures selected by the ABPS from the list of procedures
• Pass Part II of the certification examination in foot surgery

Diplomates certified in foot surgery must recertify every 10 years.
To become board-qualified in RRA surgery through the ABPS, candidates must:
- Be board-qualified in foot surgery
- Submit verified residency clinical logs through Podiatry Residency Resource documenting the minimum activity volumes and surgical diversity for RRA surgery specified by CPME Document 320
- Pass Part I of the certification examination in RRA surgery

Board-qualified status is valid for seven years. To obtain board certification in RRA surgery, candidates must also:
- Be board-certified in foot surgery
- Submit a list of procedures through Podiatry Logging Service for Surgery demonstrating a diversity of surgical experience in RRA surgery
- Gain approval by the ABPS Credentials Committee of complete RRA surgery case documentation of procedures selected by the ABPS from the list of procedures
- Pass Part II of the certification examination in RRA surgery

Diplomates certified in RRA surgery must recertify every 10 years.

Positions of societies, academies, colleges, and associations

**AACPM**

The American Association of Colleges of Podiatric Medicine (AACPM) publishes the *Curricular Guide for Podiatric Medical Education*. According to the AACPM, the course of instruction for a DPM degree is four years in length. The first two years are devoted to classroom instruction and laboratory work in the basic medical sciences, including anatomy, physiology, microbiology, biochemistry, pharmacology, and pathology, with some clinical exposure.

Third- and fourth-year students concentrate on courses in the clinical sciences, gaining experience in community and college clinics and in accredited hospitals. Clinical courses include general diagnosis (history taking, physical examination, clinical laboratory procedures, and diagnostic radiology), therapeutics (pharmacology, physical medicine, orthotics, and prosthetics), anesthesia, and surgery.

**APMA/CPME**

The APMA website includes a section, available to association members only, that is devoted to hospital privileging and credentialing. The CPME is an autonomous accrediting agency for podiatric medical education. Deriving its authority from the House of Delegates of the APMA, the council has final authority for accreditation of colleges of podiatric medicine, approval of fellowships, residency programs, and sponsors of continuing education, as well as recognition of specialty certifying boards for podiatric medical practice.
In its *Standards and Requirements for Approval of Podiatric Medicine and Surgery Residencies*, the CPME states that the podiatric medicine and surgery residency is a resource-based, competency-driven, assessment-validated program that consists of three years of postgraduate training in inpatient and outpatient medical and surgical management. All required curricular elements must be completed within 36 months. Additional educational experiences may be added to the curriculum allowing up to 48 months. Programs that extend the residency beyond 36 months must present a clear educational rationale consistent with program requirements.

The CPME and the Residency Review Committee view the following experiences to be essential to the conduct of a residency (although experiences need not be limited to the following):

- Clinical experience providing an appropriate opportunity to expand the resident’s competencies in the care of diseases, disorders, and injuries of the foot and ankle and their governing and related structures by medical, biomechanical, and surgical means
- Clinical experience providing participation in complete preoperative and postoperative patient care in order to enhance the resident’s competencies in the perioperative care of diseases, disorders, and injuries of the foot and ankle and their governing and related structures
- Clinical experience providing an opportunity to expand the resident’s competencies in the breadth of podiatric and non-podiatric medical and surgical evaluation and management
- Didactic experience providing an opportunity to expand the resident’s knowledge in the breadth of podiatric and non-podiatric medical and surgical evaluation and management

The curriculum must provide the resident a sufficient volume and diversity of experiences in the supervised diagnosis and management of patients with a variety of diseases, disorders, and injuries through achievement of the competencies listed below:

- Prevent, diagnose, and medically and surgically manage diseases, disorders, and injuries of the pediatric and adult lower extremity
  - Perform and interpret the findings of a thorough problem-focused history and physical examination, including problem-focused history, neurologic examination, vascular examination, dermatologic examination, musculoskeletal examination, biomechanical examination, and gait analysis
  - Formulate an appropriate diagnosis and/or differential diagnosis
  - Perform (and/or order) and interpret appropriate diagnostic studies, including:
    - Medical imaging, including plain radiography, stress radiography, fluoroscopy, nuclear medicine imaging, MRI, CT, diagnostic ultrasound, vascular imaging
    - Laboratory tests in hematology, serology/immunology, toxicology, and
microbiology, to include blood chemistries, drug screens, coagulation studies, blood gases, synovial fluid analysis, urinalysis
- Pathology, including anatomic and cellular pathology
- Other diagnostic studies, including electrodiagnostic studies, noninvasive vascular studies, bone mineral densitometry studies, compartment pressure studies
  - Formulate and implement an appropriate plan of management, including:
    - Direct participation of the resident in the evaluation and management of patients in a clinic/office setting
  - Performance of biomechanical cases and management of patients with lower extremity disorders utilizing a variety of prosthetics, orthotics, and footwear
    - Management when indicated, including:
      - Dermatologic conditions
      - Manipulation/mobilization of foot/ankle joint to increase range of motion/reduce associated pain and of congenital foot deformity
      - Closed fractures and dislocations including pedal fracture/dislocation and ankle fracture/dislocation
      - Cast management
      - Tape immobilization
      - Orthotic, brace, prosthetic, and custom shoe management
      - Footwear and padding
      - Injections and aspirations
      - Physical therapy
      - Pharmacologic management, including the use of NSAIDs, antibiotics, antifungals, narcotic analgesics, muscle relaxants, medications for neuropathy, sedative/hypnotics, peripheral vascular agents, anticoagulants, antihyperuricemic/uricosuric agents, tetanus toxoid/immune globulin, laxatives/cathartics, fluid and electrolyte management, corticosteroids, anti-rheumatic medications
    - Surgical management when indicated, including:
      - Evaluating, diagnosing, and selecting appropriate treatment and avoiding complications
      - Progressive development of knowledge, attitudes, and skills in preoperative, intraoperative, and postoperative assessment and management in surgical areas including, but not limited to, digital surgery, first ray surgery, other soft tissue foot surgery, other osseous foot surgery, RRA surgery (added credential only), other procedures (see below regarding the volume and diversity of cases and procedures to be performed by the resident)
    - Anesthesia management when indicated, including local and general, spinal, epidural, regional, and conscious sedation anesthesia
    - Consultation and/or referrals
    - Lower extremity health promotion and education
  - Assess the treatment plan and revise it as necessary
• Direct participation of the resident in urgent and emergent evaluation and management of podiatric and non-podiatric patients
• Assess and manage the patient’s general medical and surgical status
  – Perform and interpret the findings of comprehensive medical history and physical examinations (including preoperative history and physical examination), including:
    • Comprehensive medical history
    • Comprehensive physical examination including vital signs and physical examination of head, eyes, ears, nose, and throat, neck, chest/breast, heart, lungs, abdomen, genitourinary, rectal, upper extremities, neurologic examination
  – Formulate an appropriate differential diagnosis of the patient’s general medical problem(s)
  – Recognize the need for (and/or order) additional diagnostic studies when indicated, including:
    • EKG
    • Medical imaging including plain radiography, nuclear medicine imaging, MRI, CT, diagnostic ultrasound
    • Laboratory studies including hematology, serology/immunology, blood chemistries, toxicology/drug screens, coagulation studies, blood gases, microbiology, synovial fluid analysis, urinalysis
    • Other diagnostic studies
  – Formulate and implement an appropriate plan of management, when indicated, including appropriate therapeutic intervention, appropriate consultations and/or referrals, and appropriate general medical health promotion and education
  – Participate actively in medicine and medical subspecialties rotations that include medical evaluation and management of patients from diverse populations, including variations in age, sex, psychosocial status, and socioeconomic status
  – Participate actively in general surgery and surgical subspecialties rotations that include surgical evaluation and management of non-podiatric patients including, but not limited to:
    • Understanding management of preoperative and postoperative surgical patients with emphasis on complications
    • Enhancing surgical skills, such as suturing, retracting, and performing surgical procedures under appropriate supervision
    • Understanding surgical procedures and principles applicable to non-podiatric surgical specialties
  – Participate actively in an anesthesiology rotation that includes preanesthetic and postanesthetic evaluation and care, as well as the opportunity to observe and/or assist in the administration of anesthetics. Training experiences must include, but not be limited to:
    • Local anesthesia
    • General, spinal, epidural, regional, and conscious sedation anesthesia
– Participate actively in an emergency medicine rotation that includes emergent evaluation and management of podiatric and non-podiatric patients
– Participate actively in an infectious disease rotation that includes, but is not limited to, the following training experiences:
  • Recognizing and diagnosing common infective organisms
  • Using appropriate antimicrobial therapy
  • Interpreting laboratory data including blood cultures, gram stains, microbiological studies, and antibiosis monitoring
  • Exposure to local and systemic infected wound care
– Participate actively in a behavioral science rotation that includes, but is not limited to:
  • Understanding of psychosocial aspects of healthcare delivery
  • Knowledge of and experience in effective patient-physician communication skills
  • Understanding cultural, ethnic, and socioeconomic diversity of patients
  • Knowledge of the implications of prevention and wellness
• Practice with professionalism, compassion, and concern in a legal, ethical, and moral fashion
  – Abide by state and federal laws, including HIPAA, governing the practice of podiatric medicine and surgery
  – Practice and abide by the principles of informed consent
  – Understand and respect the ethical boundaries of interactions with patients, colleagues, and employees
  – Demonstrate professional humanistic qualities
  – Demonstrate ability to formulate a methodical and comprehensive treatment plan with appreciation of healthcare costs
• Communicate effectively and function in a multidisciplinary setting
  – Communicate in oral and written form with patients, colleagues, payers, and the public
  – Maintain appropriate medical records
• Manage individuals and populations in a variety of socioeconomic and healthcare settings
  – Demonstrate an understanding of psychosocial and healthcare needs for patients in all life stages—pediatric through geriatric
  – Demonstrate sensitivity and responsiveness to cultural values, behaviors, and preferences of one’s patients when providing care to persons whose race, ethnicity, nation of origin, religion, gender, and/or sexual orientation is/are different from one’s own
  – Demonstrate an understanding of public health concepts, health promotion, and disease prevention
• Understand podiatric practice management in a multitude of healthcare delivery settings
  – Demonstrate familiarity with utilization management and quality improvement
  – Understand healthcare reimbursement
– Understand insurance issues including professional and general liability, disability, and workers’ compensation
– Understand medical-legal considerations involving healthcare delivery
– Demonstrate understanding of common business practices
• Be professionally inquisitive, lifelong learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice
  – Read, interpret, and critically examine and present medical and scientific literature
  – Collect and interpret data and present the findings in a formal study related to podiatric medicine and surgery
  – Demonstrate information technology skills in learning, teaching, and clinical practice
  – Participate in continuing education activities

The volume and diversity of cases and procedures to be performed by the resident must meet the following minimum activity volume requirements:
• Case activities
  – Podiatric clinic/office encounters: 1,000
  – Podiatric surgical cases: 300
  – Trauma cases: 50
  – Podopediatric cases: 25
  – Biomechanical cases: 75
  – Comprehensive medical histories and physical examinations: 50
• Procedure activities
  – First and second assistant procedures (total): 400
  – First assistant procedures, including:
    • Digital: 80
    • First ray: 60
    • Other soft tissue foot surgery: 45
    • Other osseous foot surgery: 40
    • RRA (added credential only): 50

A maximum of 20% of residency education is acceptable to be conducted in a podiatric private practice office-based setting.

In addition to podiatric medicine and podiatric surgery, the following rotations are required:
• Medical imaging
• Pathology
• Behavioral sciences
• Infectious disease
• Internal medicine and/or family practice
• Medical subspecialties (rotations that satisfy the medical subspecialty requirement include at least two of the following: dermatology, endocrinology,
neurology, pain management, physical medicine and rehabilitation, rheumatology, or wound care)

- General surgery
- Surgical subspecialties (training resources that satisfy the surgical subspecialty requirement must include at least one of the following: orthopedic, plastic, or vascular surgery)
- Anesthesiology
- Emergency medicine (training resources may include emergency room service, urgent care center, trauma service, and critical care unit service)

The time spent in infectious disease plus the time spent in internal medicine and/or family practice plus the time spent in medical subspecialties must be equivalent to a minimum of three full-time months of training.

Following completion of residency, a podiatrist may choose to pursue podiatric fellowship education. In its Standards and Requirements for Approval of Podiatric Fellowships, the CPME states that a podiatric fellowship must have appropriate goals and objectives that are comprehensive in addressing the body of scientific knowledge underlying the fellowship and from which a curriculum of at least 12 months in duration is derived and implemented. The academic component of the fellowship must emphasize a scholarly approach to clinical problem solving, self-directed study, development of analytic skills and surgical/treatment judgment, and research. The technical component ensures the ability of the fellow to perform skillfully the procedures and/or treatment plans required by the program. Podiatric fellowship approval is based on programmatic evaluation and periodic review by the Residency Review Committee and the CPME.

**ACFAOM**

The American College of Foot & Ankle Orthopedics & Medicine (ACFAOM) promotes understanding of the services rendered by podiatrists who devote most of their practice to podiatric orthopedics and primary podiatric medicine. It is an education, research, and advocacy organization that endeavors to advance standards of practice and quality of podiatric care.

In its Criteria for Evaluating Podiatrists for Hospital Privileges (November 2005), the ACFAOM lists the following privileges as those that would presumptively be granted to podiatrists who have completed a CPME-approved residency program:

- Consultations
- Wound care
- Podopediatrics
- Capsulotomy—forefoot
- Closed reduction of metatarsal fracture
- Excision of verruca
- Matrixectomy
• Tenotomy—forefoot
• History and physicals
• Orthotics/pedorthics
• Avulsion of toenail
• Closed reduction of digital fracture
• Excision/biopsy of cutaneous lesion
• Incision and drainage (soft tissue)
• Repair of simple laceration

In addition, podiatrists who have completed a comprehensive CPME-approved residency program would likely be granted the following privileges based on documented experience and training:
• Amputation—digital
• Arthrodesis—digital
• Arthroplasty—digital
• Arthroplasty—metatarsal phalangeal joint
• Bone biopsy—forefoot
• Excision of sesamoid
• Digital, lesser tarsus, metatarsal, and tarsal exostectomy
• Condylectomy
• Excision of accessory ossicles—forefoot
• Excision of intermetatarsal neuroma
• Excision of plantar dibromatosis
• Excision of soft tissue tumors
• Excision of metatarsal
• Joint implant—forefoot
• Open reduction and internal fixation (ORIF)—phalanges and metatarsals
• Metatarsal head resection
• Phalangeectomy
• Plantar fasciotomy
• Repair/transfer of tendon—forefoot
• Bunionectomy
• Tendon lengthening—forefoot

Podiatrists who possess documentation of additional training and experience may request additional privileges, which may include:
• Amputation—foot (except entire)
• Arthrodesis—midfoot
• Bone grafts
• Capsulotomy—rearfoot
• Capsulotomy—ankle
• Closed reduction rearfoot fracture
• Closed reduction ankle fracture
• Excision of tarsal bones
• ORIF—fractures and dislocations:
All higher-level privileging should include the preceding lower-level privileges if requested.

**ACFAS**

The American College of Foot and Ankle Surgeons (ACFAS) is a medical specialty society that seeks to promote the art and science of foot, ankle, and related lower extremity surgery; address the concerns of foot and ankle surgeons; and advance and improve standards of education and surgical skill.

In its position statement titled “Credentialing of Podiatric Foot and Ankle Surgeons and Guidelines for Surgical Delineation of Privileges” (July 2011), the ACFAS states that the credentialing processes for granting privileges for the specialty of foot and ankle surgery should be uniformly applied to all surgeons seeking foot and ankle surgery privileges, regardless of medical degree. These privileges should be based on the completion of a residency that is duly accredited by the surgeons’ official medical and surgical associations, with a focus on foot and ankle surgical training. In addition, the privileging process should evaluate specialized foot and ankle fellowship documentation, surgical residency training logs, and/or demonstration of current clinical experience at other facilities, continuing education, and accreditation, along with board certification or qualification. Specific procedural delineation is based on individual training and documented experience.

The ACFAS defines two core categories of surgical delineation:

**Core Level 1 Privileges: Foot and Ankle**

This category includes privileges to admit as qualified, evaluate, diagnose, provide consultation, order diagnostic studies, and perform surgical and nonsurgical procedures of the foot and ankle and lower leg using any necessary method within the standard of care.

- Soft tissue procedures of the foot and ankle and lower leg including: incision and drainage; lesion and mass excision; ligament and tendon repair; adjunctive tendon lengthening of the related lower leg; skin grafts, tarsal tunnel decompression
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- Osseous procedures including osteotomies of the foot; osteotomies of the foot and ankle; open and closed reduction of the forefoot and lesser tarsal fractures/dislocations; osseous fusions of the foot (excluding triple arthrodesis)
- Amputations of portions of the foot
- Extracorporeal shock wave therapy
- CO2 laser use

**Core Level 2 Privileges: Complex Rearfoot, Ankle, and Related Lower Extremity Structures**

This category includes privileges to perform procedures of complex rearfoot, ankle, and related lower extremity structures using any method within the standard of care.

- Osteotomy of the ankle and related lower leg; arthrodesis of the ankle (open and arthroscopic)
- Tendon reconstruction and transfers of the ankle and related lower leg
- Fracture management: closed and open repair of major foot and ankle fractures (os calcis and talus), ankle, and related lower leg structures; and osteoarticular cartilage grafts
- Osseous fusions of the hindfoot and ankle
- Arthroscopy of the foot and ankle

A Special Procedures category is also defined for specialized and evolving technologies and procedures. Credentialing for Special Procedures requires additional documentation of training, qualification, and postgraduate training courses specific to the procedures or technologies. Examples of such procedures are total ankle replacement and management of pilon fractures.

**ASPS**

The American Society of Podiatric Surgeons (ASPS) is an independent organization dedicated to podiatric surgical research and education. ASPS advances the knowledge and skills of podiatrists in the area of surgery of the foot, ankle, and governing and related structures so they may better service their patients, according to the organization’s website. ASPS collaborates with APMA by representing the surgical interests of APMA members.

**Positions of accreditation bodies**

**CMS**

CMS has no formal position concerning the delineation of privileges for podiatry/podiatric medicine and 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 podiatry/podiatric medicine and 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 podiatry/podiatric medicine and 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 podiatry/podiatric medicine and 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 subspecialty 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 podiatry/podiatric medicine and surgery

Basic education: DPM
Minimal formal training: To be eligible to apply for privileges in podiatry (type I), the applicant must demonstrate successful completion of a podiatric surgical residency accredited by the CPME.

To be eligible to apply for privileges in podiatry (type II), the applicant must demonstrate successful completion of at least a 24-month podiatric surgical residency accredited by the CPME, AND current board certification or active participation in the examination process leading to board certification in foot surgery by the ABPS.

To be eligible to apply for privileges in podiatry (type III or IV), the applicant must demonstrate successful completion of a 36-month podiatric surgical
residency accredited by the CPME, AND current board certification or active participation in the examination process leading to board certification in foot surgery and RRA surgery by the ABPS.

**Required current experience:** Podiatry (type I): At least \([n]\) type I podiatric procedures, reflective of the scope of privileges requested, during the past 12 months or successful completion of a CPME-accredited training program within the past 12 months.

Podiatry (type II, III, or IV): At least \([n]\) type II, type III, or type IV podiatric procedures, respectively, reflective of the scope of privileges requested, during the past 12 months, or successful completion of a CPME-accredited podiatric surgical residency 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 podiatry/podiatric medicine and surgery**

Core privileges in podiatry (type I) include the ability to co-admit, evaluate, diagnose, provide consultation to, order diagnostic studies for, and treat the foot by mechanical, medical, or superficial surgical means on patients of all ages.

Core privileges in podiatry (type II) include the ability to co-admit, evaluate, and treat patients of all ages with podiatric problems/conditions of the forefoot, midfoot, and nonreconstructive hindfoot.

Core privileges in podiatry (type III) include the ability to co-admit, evaluate, diagnose, provide consultation to, and order diagnostic studies for patients and treat the forefoot, midfoot, rearfoot, reconstructive and nonreconstructive hindfoot, and related structures by medical or surgical means.

Core privileges in podiatry (type IV) include the ability to co-admit, evaluate, and treat patients of all ages with podiatric problems/conditions of the ankle, including procedures involving osteotomies, arthrodesis, and open repair of fractures of the ankle joint; and assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services.

Core privileges in podiatry/podiatric medicine and surgery include the privileges and procedures on the following procedures lists and such other procedures that are extensions of the same techniques and skills.
Type I

- Soft tissue surgery involving a nail or plantar wart excision, avulsion of toenail, excision or destruction of nail matrix or skin lesion, removal of superficial foreign body, and treatment of corns and calluses
- Ordering and interpretation of diagnostic tests related to podiatric patients and application or prescription of foot appliances, orthotics, shoe modifications, and special footwear
- Prescribing medications commonly used in the practice of podiatry

Type II

- Anesthesia (topical, local, and regional blocks)
- Debridement of superficial ulcer or wound
- Digital exostectomy
- Digital fusions
- Digital tendon transfers, lengthening, and repair
- Digital/ray amputation
- Excision of benign bone cysts and bone tumors of the forefoot
- Excision of sesamoids
- Excision of skin lesions of the foot and ankle
- Excision of soft tissue masses (neuroma, ganglion, and fibroma)
- Hallux valgus repair with or without metatarsal osteotomy (including the first metatarsal cuneiform joint)
- Implantation of arthroplasty forefoot
- Incision and drainage/wide debridement of soft tissue infections
- Incision of onychia
- Metatarsal excision
- Metatarsal exostectomy
- Metatarsal osteotomy
- Midsartal and tarsal exostectomy (including posterior calcaneal spur)
- External neurolysis/decompression (including tarsal tunnel)
- Onychoplasty
- Open/closed reduction, digital fractures
- Open/closed reduction, metatarsal fractures
- Plantar fasciotomy with or without excision of calcaneal spur
- Removal of foreign bodies
- Syndactyization of digits
- Tenotomy/capsulotomy, digits
- Tenotomy/capsulotomy, metatarsal and phalangeal joints
- Treatment of deep wound infections, osteomyelitis

Type III

- Excision of accessory ossicles, midfoot and rearfoot
- Excision of benign bone cyst or bone tumors, rearfoot
- Neurolysis of nerves, rearfoot
- Open/closed reduction of foot fractures other than digital or metatarsal, and
excluding calcaneal
- Osteotomies of the midfoot and rearfoot
- Polydactylism revisions
- Rearfoot fusions
- Skin grafts
- Syndactylism revisions
- Tarsal coalition repairs
- Tendon lengthening (nondigital)
- Tendon rupture repairs (nondigital)
- Tendon transfers (nondigital)
- Tenodesis
- Traumatic injury of foot and related structures

Type IV
- Ankle fusion
- Ankle stabilization procedures
- Arthrodesis tarsal and ankle joints
- Arthroplasty, with or without implants, tarsal and ankle joints (e.g., subtalar joint arthrodesis)
- Major tendon surgery of the foot and ankle, such as tendon transpositionings, recessions, and suspensions
- Open and closed reduction fractures of the ankle
- Osteotomy, multiple tarsal bones (e.g., tarsal wedge osteotomies)
- Osteotomy, tibia and fibula
- Surgical treatment of osteomyelitis of ankle
- Plastic surgery techniques involving midfoot, rearfoot, or ankle

Special noncore privileges in podiatry/podiatric medicine and 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:
- Extracorporeal shock wave therapy (orthotripsy)
- Ankle arthroscopy
- 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 privileges in podiatry, the applicant must have current demonstrated competence and an adequate volume of experience ([n] type I, type II, type III, or type IV podiatric procedures, respectively) 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 is required of all applicants for renewal of privileges.

In addition, continuing education related to podiatry/podiatric medicine and surgery should be required.

For more information

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Telephone: 310-375-0700
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Website: www.abpmed.org

**American Board of Podiatric Surgery**
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Website: www.abps.org

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Website: www.acfaom.org

**American College of Foot and Ankle Surgeons**
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American Podiatric Medical Association
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Telephone: 301-581-9200
Website: www.apma.org

American Society of Podiatric Surgeons
9312 Old Georgetown Road
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Website: www.aspsmembers.org

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
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Website: www.cms.hhs.gov

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142 East Ontario Street  
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Oakbrook Terrace, IL 60181  
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