Credentialing and Corrective Action: Protecting Patients and Hospitals

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August 17, 2023

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Overview

- Credentialing and privileging standards and processes
- Medical Staff corrective action
- Protecting Peer Review Privilege
- Reporting adverse action
- Defenses and protections

Credentialing

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Who Must Be Credentialed?

- All licensed independent practitioners ("LIP"), *i.e.*, those who may order tests or procedures at the hospital, *e.g.*,
  - Physicians (*e.g.*, MDs and DOs)
  - Podiatrists
  - Dentists and oral surgeons
  - Advance practice nurses
  - (*e.g.*, NPs, CRNAs, CNWs, etc.)
  - Physician assistants
  - Psychologists
  - Therapists
  - Chiropractors
  - Others?

Sometimes referred to in bylaws as "Limited License Practitioners"

Sometimes referred to in bylaws as "Allied Health Professionals" or "Advanced Practice Professionals"

- "Credentialing" may not apply to others (*e.g.*, nurses, techs, etc.), but must ensure they are qualified.

What Does Credentialing Address?

Medical staff membership
("part of the club")

- Group of practitioners with privileges at facility.
- Membership = certain rights, privileges, and responsibilities.
- Must apply for membership.
- Facility's governing board may grant or deny membership.

Clinical privileges
("what they can do at hospital")

- Privileges = privilege to perform specified services or procedures at facility.
- Must apply for privileges.
- Facility's governing board may grant or deny privileges.

Why Credentialing?

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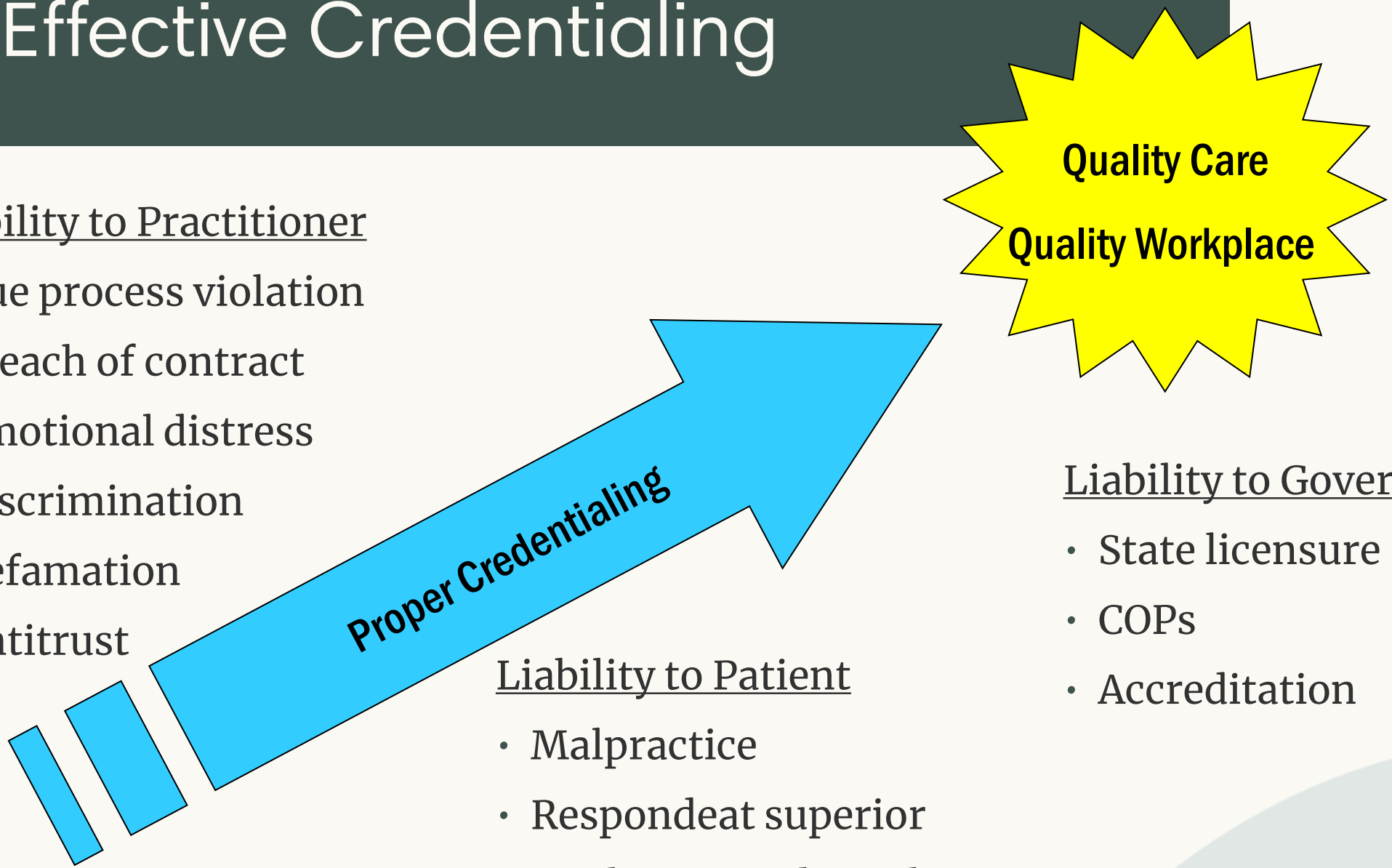
Why Credentialing?

- Proper credentialing = preventive medicine
  - Promotes quality healthcare.
  - Avoids problem practitioners.
    - Incompetent.
    - Disruptive.
    - Poor fit for organization.
  - Facilitates a professional workplace.
  - Increasingly important for reimbursement in healthcare reform.
  - Prevents liability to patients, practitioners, employees, and the government.

Effective Credentialing



Liability to Practitioner

- Due process violation
- Breach of contract
- Emotional distress
- Discrimination
- Defamation
- Antitrust

Liability to Patient

- Malpractice
- Respondeat superior
- Negligent credentialing

Liability to Government

- State licensure
- COPs
- Accreditation

Credentialing: Liability to Patient and Government

- To minimize liability to patient:
  - Ensure you have qualified practitioners on staff.
  - Conduct proper credentialing.
    - Initial medical staff appointment and privileges.
    - Biannual re-credrentialing.
    - Peer review ("Ongoing Professional Practice Evaluation").
    - Corrective action when needed.

Credentialing: Liability to Practitioner

- Practitioners who are denied privileges may sue.
  - Denial may inhibit the practitioner's ability to practice in the community if cannot provide services at local facility or contract with certain payers.
  - Reported denials may adversely affect practitioner's privileges at other facilities, ability to get a job, or ability to contract with certain payers.
    - Adverse action against privileges may be reported to:
      - National Practitioners Data Bank.
      - State medical boards.
    - Payer or services contracts may be conditioned on privileges.

Credentialing: Liability to Practitioner

- Courts usually do not second guess organization's decision if:
  - Followed standards in bylaws and statutes.
  - Based on legitimate, documented reasons
    - Patient care or facility operations
    - NOT arbitrary or capricious
    - NOT improper motive, e.g., discrimination, anticompetition, retaliation, etc.
- From legal liability standpoint, the **process** is more important than the **decision**.

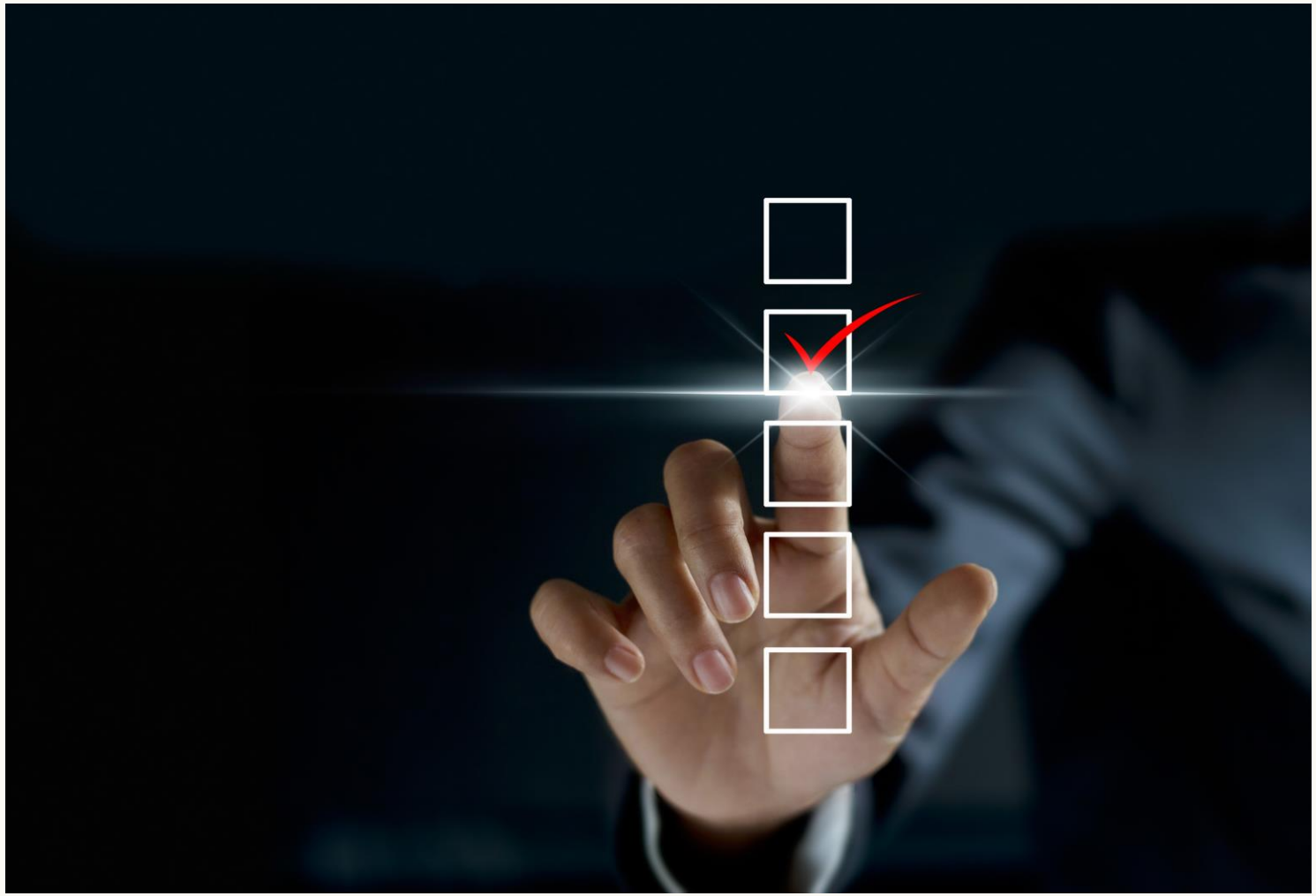
Credentialing Decisions

Ensure your credentialing decisions:

- Are based on documented, legitimate reasons.
  - Not unreasonable, arbitrary, capricious or discriminatory.

- Are consistent with the process and standards in applicable statutes, bylaws, rules and regulations, and accreditation requirements.

Credentialing Standards



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Credentialing Standards

- Statutes and regulations
  - Constitution
  - State Laws
  - Hospital/CAH COPs, 42 CFR 482.12, -.22 and 45 CFR 601
  - Health Care Quality Improvement Act, 42 USC 11101
- Medical staff bylaws, rules and regulations
- Practitioner contracts
- Accreditation standards
- Common law, *e.g.*, standard in community to avoid negligent credentialing claim (where applicable)

Credentialing Standards

- Constitution
  - Practitioner does not have a constitutional right to privileges at a *public hospital*. *Hayman v. Galveston* (S.Ct. 1927)
  - Once privileges granted at a *public hospital*, practitioner **may** have a property or liberty interest requiring due process before they are denied.
  - Hospital may not deny privileges for reasons prohibited by the constitution, *e.g.*, racial discrimination.

Credentialing Standards: Summary

Hospital must establish **reasonable** criteria for medical staff membership and privileges, *e.g.*,

- Licensure, scope of practice, education, training, experience, physical and mental capability, judgment, character
- Professional conduct
- Capability of hospital
- Geographic proximity
- Any other reasonable, legal bases

NOT soley based on:

- Professional membership or certification
- Based on other credentialing done by others
- Illegal bases, *e.g.*, discrimination, antitrust, etc.

Hospital must provide some level of due process, *e.g.*,

- Application
- Review by active staff
- Notice
- Hearing and appeal
- Decision by governing body

Check your state laws, bylaws, policies, and actual processes for compliance!

Credentialing Standards

What about economic or business reasons?

- Exclusive contracts
- Closed staff arrangements
- Competitors on medical staff

Most courts have upheld if legitimate and consistent with bylaws.

- Utilization (*i.e.*, "economic credentialing")
  - OIG has expressed fraud and abuse concerns
  - "conditioning privileges on a particular number of referrals or requiring the performance of a particular number of procedures, beyond volumes necessary to ensure clinical proficiency, potentially raise substantial risks under the [anti-kickback] statute."

Med Staff Categories

Must assign medical staff members to a medical staff category, *e.g.*,

- Active
- Courtesy
- Consulting
- Honorary
- Telemedicine
- Allied health professional
- Other?

For each, identify:

- **Qualifications**
- **Privileges or rights**
- **Responsibilities**
- **Ability to modify**

Medical Staff Categories

- May have "tiers" or different types of medical staff members:
  - Physicians (MD, DO)
  - Limited license practitioners (DPM, DDS, DMD, etc.)
  - Allied health professionals/advanced practice professionals (PA, NP, CRNA, CNW, others)
- Medical staff privileges and rights may differ between types, *e.g.*,
  - Admissions
  - Clinical services
  - Voting
  - Medical staff offices
  - Full fair hearing rights

Medical Staff Categories

Should mid-levels be full medical staff members or members of allied health professional staff?

Pros

- Promotes unity on staff
- Helps ensure smaller hospitals have critical mass
- May facilitate accreditation

Cons

- May complicate bylaws as you distinguish between what mid-levels can and cannot do.
- May give them rights / responsibilities that are not required or appropriate (e.g., full voting, med staff officer, full hearing rights, etc.)

Privileges

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Privileges

Ensure privileges are:

1. appropriate based on education, competence, and experience;
2. based on Medical Staff recommendation;
3. allowed under Bylaws/Credentials Policy; and
4. allowed under state law, *e.g.*, admitting privileges for PAs, APRNs, etc.

Also consider contract limitations, *e.g.*, exclusive contracts.

Scope of Practice: Physician Assistants/APRNs

- Ensure you have supervision required under state law (*e.g.*, supervising physician for a PA) and required agreements under state law (*e.g.*, delegation of services agreement for a PA), as required under applicable state law.
  - Ensure any agreement has the necessary components under state law and allows the practitioner to exercise the desired privileges.
- Many states have modified or removed supervision requirements for PAs, under certain circumstances, and most states allow APRNs to independently practice, with few exceptions.
  - However, the hospital still has the right to require supervision/a sponsoring physician.

Physician Involvement in Care

- **State Law**: Look to state law to ensure proper physician involvement in care. For example, some states require that every patient be under the care of a physician licensed in that state. (*See* Utah Admin. Code R432-100-7(4), IDAPA 16.03.14.200; see also 42 CFR 482.22(b) for Medicare patients)

- **Medicare COPs**:
  - Every Medicare patient [must be] under the care of:

    (i) A doctor of medicine or osteopathy;

    (ii) A doctor of dental surgery or dental medicine … acting within the scope of his or her license;

    (iii) A doctor of podiatric medicine … with respect to functions which he or she is legally authorized by the State to perform;

    (iv) A doctor of optometry who is legally authorized to practice optometry by the State…;

    (v) A chiropractor who is licensed by the State or legally authorized to perform the services …; and

    (vi) A clinical psychologist, but only with respect to clinical psychologist services … to the extent permitted by State law. (42 CFR 482.12(c)(1))

Podiatrists, Dentists, Psychologists

- Note that many states require that hospitals allow podiatrists, dentists, and/or psychologists to be on the medical staff.

(*See* Utah Admin. Code R432-100-7(5), IC 39-1395)

Credentialing Process

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Credentialing Process

Process usually set out in medical staff bylaws and policies.

- Application
  - Gather information
  - Verify information
  - Databank searches

Administration
(*e.g.*, Medical Staff Services)

- Active medical staff review
  - Review file
  - Interview practitioner
  - Recommendation to board
  - Fair hearing process, if required
- Board review and decision

* *Process may vary for physicians v. allied health professionals.*

Credentialing Process

- Consider 2-step process
  - Screening for basic eligibility requirements (*e.g.*, education, licensure, geographic proximity).
    - Reviewed by medical staff office.
    - Application denied summarily if fail to meet basic objective qualifications.
  - Review for competence and capability.
    - Reviewed by medical staff.
    - Only applies if satisfied basic qualifications.
- Benefits
  - May weed out ineligible applicants.
  - May avoid fair hearing process and NPDB reports.

Credentialing Process

- Put burden on applicant to produce relevant and required info and documents.
  - You should not be required to chase down info.
  - Notify applicant of deficiencies, *e.g.*, missing info or incomplete answers.
  - Notify applicant that you cannot process application until completed application is submitted.
- Confirm that misrepresentations in application are basis for automatic denial.
- Note that some states have a limit for the number of days a hospital has to process a complete application.

Credentialing Process

- Ensure databanks are queried.
  - National Practitioners Data Bank
    - Hospital charged with knowledge of info in NPDB.
    - Print and retain report.
  - List of Excluded Individuals and Entities
    - Cannot contract with excluded provider.
    - Cannot bill for services ordered by excluded provider.
  - Federation of State Medical Boards (FSMB)
  - State professional boards
    - Some states require certain queries.

Credentialing Process

Beware red flags

- References indicate problems
- Discrepancies in info submitted
- Privileges requested vary from usual requests
- Unexplained gaps in time
- Loss or reduction in privileges, licensure, program participation, etc.
- Prior disciplinary actions
- Three or more malpractice claims in last five years
- Numerous jobs or affiliations in last five years
- More than five licenses across United States
- Unexplained refusal to disclose info
- Anything else that raises concerns

Credentialing Process

Following review, medical staff may:

- Require additional information, examination, or review.
- Recommend that membership and specified privileges be granted.
- Recommend that membership and/or privileges be denied, limited, or conditioned.
  - Usually triggers fair hearing process under bylaws.
- *Check bylaws requirements.*

Credentialing Process

- Upon receipt of medical staff recommendation, board may
  - Accept recommendation.
  - Reject recommendation.
  - Send back for more action.
  - Take its own action, *e.g.*, impose conditions.
- Board should review medical staff recommendation:
  - Appropriate process was followed consistent with statutes, bylaws, rules and regulations.
  - Decision is reasonable, not arbitrary or capricious.
  - Decision was based on legitimate considerations, not illegal considerations.
- Board is not required to be medical experts.

Credentialing: Telemedicine Privileges

- Hospital and Critical Access Hospital CoPs now allow hospital to rely on credentialing done by remote hospital/entity if:
  - Have written agreement with distant site.
  - Distant site complies with CoP standards.
  - Practitioner privileged at distant site.
  - Practitioner licensed in state where services provided.
  - Hospital reviews practitioner's performance and provides results to distant site.

(42 CFR 482.12 and .22, and 485.616 and .635)

- *Confirm it is allowed by bylaws and state law.*
- *Confirm it does not trigger fair hearing rights.*
- *Consider exposure to negligent credentialing claim.*

Credentialing: Emergency or Temporary Privileges

- In limited circumstances, hospital may grant privileges on emergency or temporary basis, *e.g.*,
  - Practitioner needed but no time for full process.
  - Privileges temporarily granted while formal application processed.
- Subject to expedited review.
- Automatically expires within limited time period, *e.g.*, 60 days.

- *Be very careful and use sparingly.*
- *Ensure bylaws allow for same.*
- *Ensure all required verifications are received and all licenses are in place prior to granting (e.g., state license, state-controlled substance license, etc.)*

Credentialing: Reappointment

- Usually must occur at least every 2 years.
- Process similar to initial appointment.
  - Application
  - Review by active staff
  - Governing body determination
- Process should be stated in bylaws, rules or regulations.
- Beware situations where reappointment process allowed to drag on or not completed.

Corrective Action

Corrective Action

- Organization has right to ensure effective operations.
- Organization has duty to protect patients and employees.
- Medical staff responsible for medical care, professional practices, and ethical conduct of members. (42 CFR 482.12; *see* also applicable state law)
  - Clinical concerns
  - Ethical concerns
  - Behavioral concerns (*e.g.*, disruptive conduct)
  - Compliance (*e.g.*, laws, bylaws, rules, regulations)
  - Licensure, credentials, program participation

Corrective Action: The Conundrum

Fail to act:
may be liable to patient, employees, or regulators, *e.g.*,

- Malpractice
- Negligent credentialing
- Negligent supervision
- Harassment
- Regulatory violation

Act improperly:
may be liable to practitioner, *e.g.*,

- Breach of contract
- No due process
- Antitrust
- Discrimination
- Defamation
- Interference with contract or business
- Emotional distress

Corrective Action: The Good News

- Courts usually do not second guess an organization's corrective action if:
- Decision based on appropriate factors.
  - Valid patient care or business reason, not discrimination, retaliation, or unfair competition.
  - Not arbitrary and capricious.
  - Practitioner given process required by contract, bylaws, or laws.

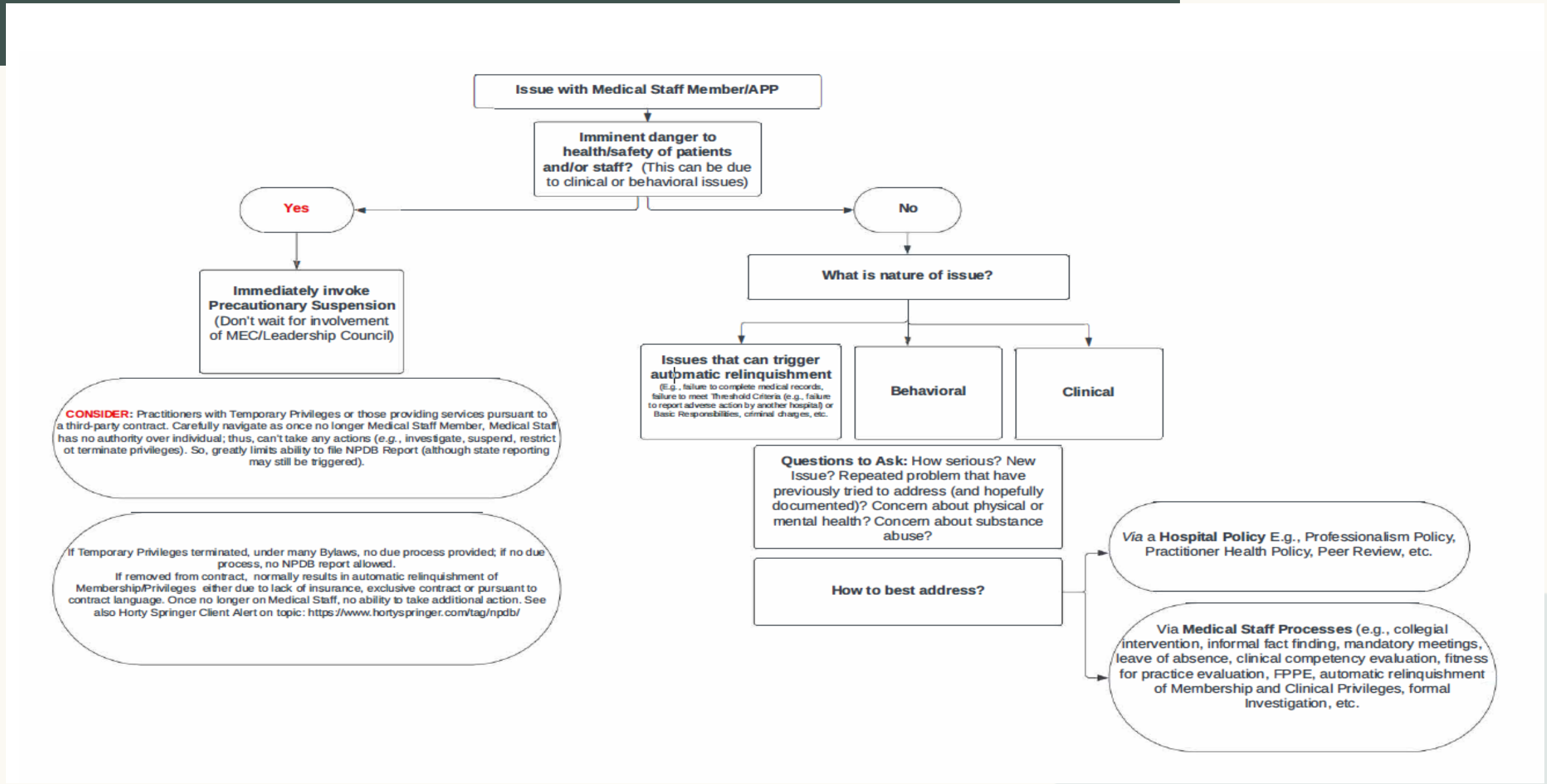
* Remember: From legal liability perspective, **the process** is usually more important than the result.

Corrective Action

Make sure action is consistent with:

- Practitioner's contract, if any
- Bylaws, policies, and procedures
- Statutes and regulations
- Constitutional due process, if public entity
- Health Care Quality Improvement Act (HCQIA), if action involves physicians

Corrective Action: Overview and Additional Considerations



Automatic Action, *e.g.*, Termination or Suspension

- Specify grounds in the bylaws and contracts, *e.g.*,
  - Loss of licensure or DEA number
  - Loss of liability insurance
  - Exclusion from Medicare/Medicaid
  - Conviction of felony or healthcare fraud
  - Failure to complete medical records
  - Termination of exclusive contract
  - Adverse action by other facility?
- Specify process in bylaws
- Identify entity who may terminate or suspend
- Do not require full hearing process?
- Coordinate with contracts
- Termination of contract = termination of privileges

Permit expedited process

Corrective Action: Informal Response

- Facts may warrant informal response, *e.g.*,
  - Practitioner interview
  - Oral or written reprimand and warning
  - Chart review or proctoring
  - Counseling and treatment
  - Education and training
  - Voluntary remediation agreements
- Ensure bylaws do not require progressive discipline.
- Informal response probably not reportable to NPDB because no action taken against privileges.
- Document action in file.
  - May support future action.
  - May help avoid negligent credentialing claim.

Corrective Action: Investigation

- Facts may require formal investigation.
  - Note that for purposes of NPDB reporting, NPDB interprets "investigation" broadly and Hospital's definition of "investigation" isn't determinative.
- Consider notifying practitioner of investigation.
- Avoid identifying complainants.
- Warn against retaliation or improper contact.
- Remind practitioner of obligation to cooperate.
- If complaint involves serious allegations or difficult practitioner, consider involving attorney to ensure compliance with applicable standards.

Corrective Action: Investigation

- Appoint investigating entity.
  - Specify process in bylaws, rules, and regulations.
  - Use fair and balanced professionals.
  - Use peers (*i.e.*, qualified physicians in same or similar specialty) if possible.
  - Avoid using competitors or persons with conflict.
  - Avoid using anyone who may be needed to serve on a hearing panel if it goes that far.
  - Consider using outside reviewers, *e.g.*, peer review network.

Corrective Action: Investigation

- Educate participants in investigation
  - Scope of investigation.
  - Relevant substantive standards that apply to misconduct and investigation.
  - Procedures found in bylaws, rules and regulations.
  - Standards for judicial review.
  - Statutory immunity if act in good faith
    - HCQIA
    - Volunteer Protection Act
    - Tort Claims Act, if government entity
  - Importance of maintaining confidentiality.

Corrective Action: Investigation

- Conduct fair investigation.
  - HCQIA: Entity must make "a reasonable effort to obtain the facts of the matter."
  - Review documents
  - Interview witnesses
  - Consult experts
- Scope depends on seriousness of charges.
- Investigator should be careful not to unilaterally expand scope of investigation.
- If new matters are discovered, report back to appointing entity for action.
- Organization will be judged by investigative record.

Corrective Action: Investigation

- Document legitimate actions, considerations, and conclusions in a written report to MEC or similar entity.
  - Will help ensure a well-reasoned conclusion.
  - Will support HCQIA immunity.
  - Will support decision on judicial review.
- Assume that report will be discoverable, *e.g.*,
  - To physician in proceeding
  - To board of medicine
  - To court in trial
  - Beware improper considerations or motivations.
  - Consider having legal counsel review before finalized.

Corrective Action: Recommendation

- Determine recommendation to governing body.
- If recommend outcome favorable to practitioner, make recommendation to board.
- If recommend adverse action that would trigger hearing rights,
  - Notify practitioner of right to request hearing per bylaws, rules and regulations, if applicable.
  - Alert board, but do not make recommendation to board.
  - Implement fair hearing process, if applicable. (More to come…)

Corrective Action: Summary Suspension

- Appropriate where there is:
  - "Imminent danger to the health of any individual" (*see* HCQIA).
  - Need to remove practitioner.
- Subject to subsequent notice and hearing.
- Follow bylaws, rules and regulations if possible, including:
  - Standards for summary suspension.
  - Entity that can invoke summary suspension, *e.g.*, administrator, chief of staff, etc.
- Report to NPDB applies if physician suspension is longer than 30 days.

Corrective Action: Summary Suspension

- Notice of suspension.
  - To subject practitioner.
  - To medical executive committee, chief of staff, administrator.
  - Others who need to know to ensure practitioner complies.
- Arrange to transfer care of patients to other practitioners.
  - Consider patient wishes.
  - Beware defamation issues.

Fair Hearing Process

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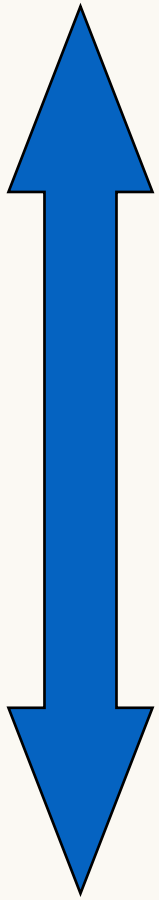
Fair Hearing Process

- Generally must give due process (fair hearing) if deny or reduce privileges based on practitioner's professional conduct that may adversely affect patient care.
  - State law
  - Bylaws, regulations and rules
  - Accreditation standards
- Process that is "due" depends on circumstances.
  - Bylaws, rules and regulations
  - Type of practitioners involved
  - Severity of action
  - Basis for action, *e.g.*, patient care
  - Contract requirements

Fair Hearing Process



- Full fair hearing process
  - Physicians
  - Denial or termination of privileges
  - Related to patient care concerns

* *Check bylaws and contract*

- Chance to complain
  - Allied health practitioners
  - Temporary or limited restriction of privileges
  - Unrelated to patient care

Health Care Quality Improvement Act (HCQIA)

- HCQIA provides immunity for most claims arising from credentialing action **against physician** if the action is taken:
  - In reasonable belief that action furthered quality care,
  - After reasonable effort to obtain facts,
  - After adequate notice and hearing procedures, and
  - In reasonable belief that action warranted by the facts.
- Hospital presumed to have complied; physician must rebut.
- Hospital process is deemed to be fair if:
  - Proper notice given
  - Hearing before a fair-minded officer or panel
  - Physician has right to present evidence
  - Physician receives written recommendation

(42 USC 11101 *et seq.*)

Fair Hearing

- Review fair hearing process:
  1. Limit to those proceedings based on professional competence that may adversely affect patient care.
  2. Physicians: compliance with HCQIA.
     - Usually requires formal process.
  3. Other practitioners: compliance with state licensing regulations, *i.e.*, "hearing and appeal."
     - May be abbreviated process.
- Ensure the fair hearing:
  1. Complies with HCQIA standards, where possible.
  2. Complies with bylaws or policies.
     - If vary, get practitioner's approval, if possible.

Reporting Adverse Actions

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National Practitioners Data Bank (NPDB)

Hospitals must report:

1. Professional review actions that adversely affect a physician's or dentist's clinical privileges **for a period of more than 30 days if the action was based on the practitioner's professional competence or conduct**.
   - Includes reducing, restricting, suspending, revoking, or denying privileges (any privileges—even temporary, emergency, or disaster) based on concerns related to professional competence or conduct.
   - Don’t forget about proctoring. If, as a result of a professional review action related to professional competence or conduct, a proctor is required for a physician or dentist to proceed in freely exercising clinical privileges, and the period lasts longer than 30 days, the action must be reported to the NPDB.
   - Clinical privileges actions are reportable once they are made final by the health care entity. However, summary suspensions lasting more than 30 days are reportable even if they are not final.

- For the above restrictions, must provide some due process (even for Temporary Privileges being terminated or restricted) or the NPDB report will be overturned, if challenged.
- Where applicable, don’t forget to file revisions to previously reported adverse clinical privileges actions.

National Practitioners Data Bank (NPDB) (Cont'd)

Hospitals must report:

- Acceptance of a physician's or dentist's surrender or restriction of clinical privileges while under investigation for possible professional incompetence or improper professional conduct, or in return for not conducting such an investigation or not taking a professional review action that otherwise would be required to be reported to the NPDB.
  - NPDB interprets the word "investigation" expansively; not governed by the Hospital's definition.
  - Physician does not need to be aware of the investigation.
- Voluntary withdrawal of a renewal application for medical staff appointment or clinical privileges while under investigation for possible professional incompetence or improper professional conduct, or in return for not conducting such an investigation or not taking a professional review action.

National Practitioners Data Bank (NPDB) (Cont'd)

- May report actions against other licensed healthcare practitioners.
- The hospital has 30 days from when the event occurs, to report (but if miss deadline, doesn't negate obligation to report).
- Any hospital or other health care entity that fails substantially to report adverse actions will have its name published in the Federal Register, and the organization will lose its immunity from liability under HCQIA with respect to professional review activities for a period of 3 years, commencing 30 days from the date of publication in the Federal Register.

NPDB

- No liability for making NPDB report so long as report is made "without knowledge of the falsity of the information contained in the report." (42 USC 11137(c))
  - *Brown v. Presbyterian Healthcare* (10th Cir. 1996): Hospital not immune where it improperly checked incompetence/ malpractice/negligence."

** Be careful what you include in report. Consider having outside legal counsel review and/or draft.*

** Consider checking "other" and writing appropriate description.*

NPDB

- Must keep NPDB report confidential.
  - May disclose to others as part of peer review process.
  - May not disclose outside of peer review process without authorization of physician.
  - Confidentiality does not apply to original records from which the NPDB report was generated.
- $11,000 fine for improper disclosure.

State Boards of Medicine

Utah	Idaho	Alaska
UCA § 58-13-5 **Within 60 days, must report to DOPL if one of following events occur with licensed health care providers (anyone licensed by DOPL):** • Terminating, suspending, or restricting membership or privileges for cause; • Terminating employment for cause related to the employee's practice as a licensed health care provider; • Subjecting a licensed health care provider to disciplinary action for a period of more than 30 days; • Finding that a licensed health care provider has violated professional standards or ethics; • Finding of incompetence in practice as a licensed health care provider; • Finding of acts of moral turpitude by a licensed health care provider; or • Finding that a licensed health care provider is engaged in abuse of alcohol or drugs.	IC 39-1393 Generally parallels NPDB requirements; must report **within 15 days**: • Action against physician for more than 30 days based on professional competence or conduct that could adversely affect patient care. • Agreement to accept sanction for more than 30 days while under investigation or to avoid investigation.	AS 08.64.336 Must report **within 7 business days** when one of the following occur: • Revokes, suspends, conditions, restricts, or refuses to grant hospital privileges to, or imposes a consultation requirement on, a physician • A physician resigns hospital staff privileges while under investigation by the hospital or a committee of the hospital and the investigation could result in the revocation, suspension, conditioning, or restricting of, or the refusal to grant, hospital privileges, or in the imposition of a consultation requirement . • Report not required if based solely on failure to complete medical records or to attend staff or committee meetings.

State Boards of Medicine

- In general, no state law liability if one provides the report in good faith.
  - Caution: Limit disclosure to the info or records identified within the applicable statute.
    - May waive peer review privilege as to additional items
  - May not be immune for liability (*e.g.*, defamation) if provide info beyond scope of statute.

Consider Other Reporting Obligations under State Law or Hospital Policies

Under State law or a Hospital's internal policies, Hospitals may be required to report to law enforcement or licensing officials when a physician or other licensee has engaged in certain conduct. For example,

- Is diverting controlled substances.
- Commits a potential criminal act within the Hospital, such as assault, battery, etc. against a patient or staff member.

Reporting Practitioners

- Remember: Physicians, nurses, etc. may have statutory or regulatory duty to report improper conduct by other practitioners.
  - Must look to applicable state licensing laws and rules to determine obligations.

Credentialing Protections

Credentialing: Protections and Defenses

- Release or waiver of claims in bylaws and application forms
  - May not be enforceable, but may dissuade suits
- Court deference to peer reviewers
- Health Care Quality Improvement Act (HCQIA), 42 USC 11101
- Federal Volunteer Protection Act, 42 USC 14501
  - Protects volunteers paid < $500/year
- Local Govt Antitrust Act, 15 USC 34
  - Protects govt hospitals
- Relevant State Laws
  - Protects govt hospitals
- State Peer Review Privilege statutes.

State Peer Review Immunity

- Most state's Peer Review Statute provides immunity from civil liability for those involved in peer review activities.
- Note that this immunity may not extend to the ultimate credentialing decision by hospital. (*e.g.*, *Harrison v. Binnion* (Idaho 2009))

Peer Review Privilege

- **Maintain the confidentiality of peer review information, documents and proceedings at all costs!**

- May waive privilege by intentional or perhaps inadvertent disclosures!

Peer Review Privilege

Maintaining the privilege

- Adopt and consistently follow a policy or practice against disclosure of peer review information.
  - Encourages participation in peer review.
  - Disclosures jeopardize integrity of peer review.
- Designate entities as peer review committees.
  - Bylaws, rules and regulations.
  - Appointments, correspondence, and minutes.
- Remind participants.
- Obtain HIPAA business associate agreements if disclose to persons outside hospital (*e.g.*, attorney, peer reviewer, etc.).

Peer Review Privilege

- Peer review documents generally not subject to State's Public Records Act (equivalent of FOIA), but there are exceptions.
- In some states, a plaintiff in malpractice action may obtain limited information concerning peer review activities.
- Peer review may be discoverable in federal court.
- May decide to waive privilege to defend hospital in litigation and obtain HCQIA immunity.
- So beware what you put in writing.
  - Document legitimate reasons.
  - Do not include or consider improper factors.

Additional Resources

- Holland & Hart
  - Healthcare
  - Health Law Blog

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