

Hendrick Medical Center Brownwood

Credentials Policy

Table of Contents

Article 1	Application Policy	1
	Section 1.3 Appointment Considerations	1
Article 2	Initial Appointment	3
	Section 2.3 Procedure for Processing	4
	Section 2.4 Responsibilities for Producing Information	7
	Section 2.5 Content of Application	8
	Section 2.6 Initial Application Categories	10
	Section 2.7 Department Chiefs Report	11
	Section 2.8 Credentials Committee Action	11
	Section 2.9 Medical Executive Committee Action	12
	Section 2.10 Application after Adverse Appointment Decision	13
	Section 2.11 Time Periods for Processing	13
	Section 2.12 Denial for Hospital's Inability to Accommodate	13
Article 3	Reappointment	14
	Section 3.1 Information Collection & Verification	14
	Section 3.2 Procedure for Processing	16
	Section 3.3 Medical Record Delinquency Rates	18
Article 4	Clinical Privileges	19
	Section 4.1 Exercise of Privileges	19
	Section 4.2 Privileges in General	19
	Section 4.3 Review of Clinical Privileges	20
	Section 4.4 Temporary Privileges	20
	Section 4.5 Termination of Temporary	22
	Section 4.6 Rights of the Practitioner with Temporary	23
Article 5	Practitioner Providing Contractual Services	24
	Section 5.1 Exclusive Policy	24
	Section 5.2 Qualifications	24
	Section 5.3 Effect of Staff Appointment Termination	24
	Section 5.4 Effect of Contract Expiration or Termination	24
Article 6	Telemedicine	25
	Section 6.1 Scope of Privileges	25
	Section 6.2 Telemedicine Physicians	25

CREDENTIALS POLICY

ARTICLE I: APPLICATION POLICY

- 1.1** As a general policy, this hospital Penates application to the Medical Staff from licensed medical and osteopathic physicians, podiatrists and dentists.

Other practitioners (Allied Health Professionals) may be permitted to apply for specific clinical privileges or other authorization to practice in the Hospital. Please refer to the Allied Health Professional policy of the Medical Staff Bylaws.

- 1.2** It is the policy of the Board of Trustees that any Practitioner meeting the basic criteria for the granting of an application may apply.

1.3 APPOINTMENT CONSIDERATIONS

Each recommendation concerning the appointment of a staff member and/or for clinical privileges to be granted shall be based upon an evidence-based assessment of the applicant's experience, ability, and current competence by the Department Chief, Credentials Committee, MEC and Board, including assessment of the applicant's proficiency in the following areas:

- 1.3.1** Patient Care with the expectation that practitioners provide patient care that is appropriate, effective, and compassionate;
- 1.3.2** Medical/Clinical knowledge of established and emerging diagnostic and therapeutic options and the application of these to patient care and educating others;
- 1.3.3** Practice-Based Learning and Improvement through demonstrated use of evidence-based medicine, and clinical experience to improve patient care practices;
- 1.3.4** Interpersonal and Communication Skills that enable establishment and maintenance of professional working relationships with patients, patient's families, members of the Medical Staff, Hospital Administration and employees, and others;
- 1.3.5** Professional Behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude to patients, the medical profession and society.
- 1.3.6** It is the policy of this hospital to provide applications for appointment to the Medical Staff to individuals who:
 - Have completed, or are in the last six (6) months of an approved ACGME residency /fellowship program, an APMA approved podiatry program, or approved ADA/GPR program;
 - Have actively practiced in a Joint Commission accredited or Medicare approved hospital at least two (2) of the past five (5) years and have no gaps in practice greater than twelve (12) consecutive months.

- 1.3.7** Provide evidence of current State physician's license (dental license or podiatric license) without stipulation and is actively pursuing application for Texas physician's license;
- 1.3.8** Must be board certified if completed residency greater than five (5) years ago or attain board certification within five (5) years of joining the medical staff and
- 1.3.9** Provide a current copy of Drug Enforcement Agency (DEA) registration, if licensed by the state of Texas. (Approved by BOT September 28, 2016)
- 1.3.10** Upon receipt of a completed application form, the Medical Staff Office shall verify its contents and shall, if the requirements of Section 1.3 herein are met, process the application as set forth in Article 3. In the event the requirements are not met, the applicant shall be notified and the application shall not be processed.

However, special situations may warrant individual consideration. The applicant may petition the Board of Trustees, through the Credentials Committee, for such consideration by providing a written request that includes a description of any extenuating circumstances.

ARTICLE 2: INITIAL APPOINTMENT

- 2.1** Application for staff appointment is to be submitted by the applicant. The application (copy attached hereby incorporated by reference) must be typed on such form as designated by the Credentials Committee and approved by the Board of Trustees. A completed copy of the Texas Standardized Credentialing Application, developed by the Texas Department of Insurance, will be accepted by the Hospital for initial application or reappointment. The applicant utilizing this form will be required to complete the Addendum to the Texas State Credentialing Application (TSCA) to collect additional information to comply with Joint Commission standards and the hospital bylaws. The applicant will have access to a copy of the Medical Staff Bylaws, Medical Staff Policies, and accompanying Rules/ Regulations of the medical staff and its departments. (Revised and Approval of BOT 8/26/2015)
- 2.2** The applicant must sign the application, thereby:
- 2.2.1** Signifying his willingness to appear for interviews in regard to his application;
 - 2.2.2** Authorizing hospital representatives to consult with others who have been associated with the applicant and/or have information bearing on his competence and qualifications;
 - 2.2.3** Consenting to hospital representatives' inspection of all records and documents that may be material to an evaluation of his professional qualifications and competence to carry out the clinical privileges he/she requests, of the applicant's physical and mental health status, and the applicant's professional and ethical qualifications;
 - 2.2.4** Releasing from any liability all hospital representatives for their acts performed in connection with evaluation of the applicant's credentials;
 - 2.2.5** Releasing from any liability all individuals and organizations that provide information, including otherwise privileged or confidential information to the hospital's representatives concerning the applicant's competence, professional ethics, character, physical and mental health, emotional stability, and other qualifications for Medical Staff appointment and clinical privileges;
 - 2.2.6** Consenting to hospital representative providing other hospitals, medical associations, licensing Boards, and other organizations concerned with provider performance and the quality and efficiency of patient care with any information relevant to such matters that the hospital may have concerning the applicant, and release hospital representatives from liability for so doing;
 - 2.2.7** Agreeing to be bound by the terms of the Bylaws, Medical Staff Policies, and appropriate Rules/Regulations thereof if granted membership and/or clinical privileges and be bound by the terms thereof without regard to whether granted membership and/or clinical privileges in all matters relating to consideration of the application;
 - 2.2.8** Agreeing to provide and update the information requested on the original application and subsequent re-application or privilege request forms (specifically, other hospitals and appointments; voluntary or involuntary limitation, reduction, suspension,

relinquishment or loss of Medical Staff membership, clinical privileges, or licensure status; any special supervision, proctoring or co-admission requirements to which the applicant has been subject in any other hospital in which the applicant has previously been granted staff privileges); and

2.2.9 Agreeing to provide any information relating to any action or investigation involving the applicant's license or practice rights by the Texas State Board of Medical Examiners or the professional licensing agency of this or any other state and of any action or investigation relating to suspension or limitation of the applicant's narcotics license or prescription rights or involvement in liability claims (including both current and pending investigations and challenges).

2.2.10 Consenting to hospital representative to obtain criminal background investigative reports on all applicants for medical staff membership. This investigative report is obtained to determine if there is any relevant information or data on a prospective medical staff member, for purposes of processing the application. Any relevant information obtained from the federal and/or state databases will be considered by the appropriate personnel/medical staff committees.

Acceptance of an application shall not be interpreted as an indication that the applicant meets the qualifications for, or shall be granted, Medical Staff membership and clinical privileges.

2.3 PROCEDURE FOR PROCESSING APPLICATION FOR STAFF APPOINTMENT

2.3.1 Upon request, eligible applicants will be given an application for appointment to the Medical Staff; privileges request form, and a detailed list of requirements for completion of the application. A complete set of Medical Staff Bylaws, Medical Staff Policies, and appropriate manuals will be made available to the applicant upon appointment.

2.3.2 The following documentation is necessary to complete an application. It is the applicant's responsibility to provide:

2.3.2.1 Completion of all blanks on the application form with necessary additional explanations and indications of privileges requested;

2.3.2.2 A copy of current Texas state license and, where applicable, Drug Enforcement Agency (DEA) and Texas Department of Public Safety registration certificates;

2.3.2.3 A statement indicating that the practitioner agrees that he/she will exhaust the administrative remedies afforded by these bylaws before resorting to final legal action, should an adverse ruling be made with respect to his/her staff membership, staff status, and/or clinical privileges;

2.3.2.4 Any current criminal charges pending against the applicant and any past convictions or pleas. The practitioner shall notify the CAO and the Chief of Staff within seven (7) days of receiving notice of the initiation of any criminal

charges, and shall acknowledge the Hospital's right to perform a background check at appointment, reappointment and any interim time when reasonable suspicion has been shown;

- 2.3.2.5** Any allegation of civil or criminal fraud pending against any applicant and any past allegations including their resolution and any investigation by any private, federal or state agency concerning participation in any health insurance program, including Medicare or Medicaid;
- 2.3.2.6** Evidence of current physical and mental health status only to the extent necessary to demonstrate that the applicant is capable of performing the functions of staff membership and exercising the privileges requested. In instances where there is doubt about an Applicant's ability to perform privileges requested, an evaluation by an external or internal source may be requested by the MEC or the Board;
- 2.3.2.7** All information concerning malpractice cases against the applicant either filed, pending, settled, or pursued to final judgment. It shall be the continuing duty of the practitioner to notify the MEC of the initiation of any professional liability action against him/her;
- 2.3.2.8** Detailed information concerning the applicant's education and training;
- 2.3.2.9** Specific requests stating the staff category and specific clinical privileges for which the applicant wishes to be considered;
- 2.3.2.10** The name and address of all other hospitals, health care organizations or practice settings with whom the applicant is or has previously been affiliated;
- 2.3.2.11** A valid, government issued ID of the applicant;
- 2.3.2.12** The names of all HMOs, PPS, and other managed care organizations in which the applicant has participated in the past three (3) years;
- 2.3.2.13** Proof of United States citizenship or legal residency;
- 2.3.2.14** For all new applicants and practitioners requesting new or additional privileges, evidence of the practitioner's professional practice review, volumes and outcomes from the organization(s) that currently privilege the applicant;
- 2.3.2.15** Detailed information concerning the applicant's experience and qualifications for the requested staff category, including information in satisfaction of the basic qualifications of the applicant;
- 2.3.2.16** Information as to previously successful or currently pending challenges to, or the voluntary relinquishment of, any of the following: (1) membership/fellowship in local, state or national professional organizations; (2) specialty board certifications; (3) license to practice any profession in any jurisdiction; (4) Drug Enforcement Agency (DEA) number/controlled

substance license (except pathologists); (5) Medical Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges; (6) the practitioner's management of patients which may have given rise to investigation by the state medical board; (7) participation in any private, federal or state health insurance program, including Medicare or Medicaid;

2.3.2.17 Satisfactory Evidence of professional liability insurance

- (a) If coverage is held with an insurer who is licensed by the Texas Board of Insurance, the applicant must provide a copy of the declaration page of current professional liability.
- (b) The Credentials Committee may consider requests from Applicants wishing to maintain coverage with an insurer, including a captive or purchasing group that is not licensed by the Texas Board of Insurance. The Credentials Committee will engage an independent consultant to assist with the business analysis of non-rated insurance carriers, including captives and risk retention groups. In order for such coverage to be considered by the Credentials Committee, the Applicant shall provide documentation and information necessary to the analysis, as requested by the consultant, within 10 working days. The documentation will be standard to the industry and should be readily available to the Applicant. The consultant's analysis and recommendation will be considered in the Committee's decision to accept or reject the evidence of professional liability insurance presented by the Applicant.

An acceptable form of insurance, meeting the criteria described in (a) above, must be in place during the review analysis of other forms of insurance.

The Medical Executive Committee and/or the Board of Trustees reserves its right to reject evidence of professional liability insurance from insurers that do not meet industry standards for having sufficient financial capacity to provide the necessary policy limits to insure their risks. The Medical Executive Committee and the Board of Trustees shall further be vested with the ultimate authority to determine whether the type, nature, scope and duration of professional liability coverage for each practitioner is sufficient, as long as such determination is reasonable, consistent with the Bylaws and this Credentials Policy, and not discriminatory in nature;

2.3.2.18 Copies of certificates or letters confirming completion of an approved residency/training program and other educational curriculum;

2.3.2.18 The names of two professional peers who have observed and worked with the applicant and who can return a questionnaire that provides adequate references pertaining to the applicant's professional competence and ethical character covering the last three years. These questionnaires shall come from deans or members of the faculty for applicants who are less than two years post-graduation from professional school;

2.3.2.19 A Practitioner profile (professional Practice Review Data) from the current

hospital of main affiliation for the last two (2) years, or residency training logs, if applicable, if a recent graduate, documenting the applicant's clinical work; and

2.3.2.20 Querying of and/or receiving information from the Boards and the National Practitioner Data Bank.

2.3.2.21 The application is considered complete when

- All blanks on the application have been completed;
- Questions about the applicant's education, training and experience have been answered;
- Any questions that have been raised during the verification process or reference collection have been addressed; and
- When the applicant has successfully provided the Credentials Committee, the Medical Executive Committee, and the Board of Trustees with all requested information.

2.4 RESPONSIBILITIES FOR PRODUCING INFORMATION

2.4.1 An applicant shall have the sole responsibility for:

2.4.1.1 Providing, and causing others to provide, all information relevant to an evaluation of the applicant's qualifications for membership and clinical privileges (i.e. schools attended, curriculum, hospitals of affiliation, and references listed); and

2.4.1.2 Resolving any doubts about these matters. Failure to do so or the withholding of adverse information shall void the application.

2.4.2 An application form, which is submitted in an incomplete manner, including failure to provide all requested documentation, will be filed as incomplete, and no further processing shall take place. The Practitioner can reapply if the necessary information and/or explanation are provided.

2.4.3 An applicant's failure to meet any of the responsibilities shall be sufficient grounds for filing the application as incomplete. The same shall be true if any person or institution fails or refuses to provide information requested on behalf of or in regard to the applicant. The Practitioner can reapply if the necessary information and/or explanation are provided.

2.4.4 Any omission or difference between the applicant's representation on the application and the information obtained in primary source verification on the application for membership or privileges shall cause the application to be filed incomplete and no further processing shall take place. The Practitioner can reapply if the necessary information and/or explanation of any differences in the information obtained in primary source verification are submitted.

2.4.5 Any refusal by the Hospital to further process an application because it is incomplete and/or due to an inability to obtain verification of the application materials shall not

entitle the affected practitioner to any of the procedural rights delineated in the Medical Staff Bylaws.

- 2.4.6** When a Practitioner's application for membership has been denied for reasons relating to professional competence or conduct, the Practitioner shall not be eligible to receive another application until or unless the reason for any adverse action no longer exists and in no event, sooner than one (1) year from the date of denial or filing as incomplete. Should the Practitioner's application be denied twice for reasons relating to professional competence or conduct, the Practitioner shall not be eligible to reapply at any time in the future.

2.5 CONTENT OF APPLICATION

NOTE: The applicant may be required to submit to a medical, psychiatric or psychological examination at the applicant's expense, if deemed appropriate, by the MEC, who may select or approve the examining physician or psychologist.

- 2.5.1** If all information required above is not submitted within forty-five (45) days of receipt of the application, it will be considered void and no further processing will take place. (One reminder notice will be sent to the applicant after receipt of the application.)
- 2.5.2** Within thirty (30) days of receipt of a completed application as defined above, the Medical Staff Office will send the applicant a letter of acknowledgement.
- 2.5.3** Only a completed application for staff membership qualifies for credentialing consideration. Upon receipt of a completed application, the Medical Staff Office will verify its contents and collect additional information such as:
- 2.5.3.1** Information from all prior and current insurance carriers concerning claims, suits and settlements (if any);
 - 2.5.3.2** Verification of all state licensure(s), current and previous;
 - 2.5.3.3** Primary source verification of education and training; and
 - 2.5.3.4** Information from the National Practitioner Data Bank (NPDB) established pursuant to the Healthcare Quality Improvement Act of 1986 and the OIG.

NOTE: The applicant has the burden of producing adequate information for a proper evaluation of his competence, character, ethics and other qualifications, and upon request of MEC or the Board of Trustees mental health status, and for resolving any doubts about such qualifications.

In the event there is undue delay in obtaining required information, the Medical Staff Office will request assistance from the applicant. In this case, the time periods for processing the application will be appropriately modified. Failure of an applicant to adequately respond to a request for assistance will, after thirty (30) days, be deemed a voluntary withdrawal from the application process.

- 2.5.4** When items 2.5.1 through 2.5.3 above have been obtained, the OIG, and state licensure will be re- verified. The file will then be summarized and presented to the appropriate Department Chief.
- 2.5.5** After receipt of the application, the Department Chief, with assistance from an active medical staff member with the same privileges if necessary, will review the entire file and document findings on a report to the Credentials Committee. This report will be added to the applicant's credentials file. The Department Chief shall sign the request for the specific clinical privileges desired by the applicant. Under unusual circumstances, the Medical Executive Committee will consider exceptions for example where there is no Active Staff member who has the requested privileges. They shall note their recommendations for any limitations of the privileges and the reason for such limitations.
- 2.5.6** If needed, the applicant will be notified to set up a clinical interview with the Department Chief.
- 2.5.7** When a Department Chief, Credentials Chair, or the Credentials Committee member(s) interview(s) an applicant, the results must be documented. A copy of the interview results will be placed in the applicant's file.
- 2.5.8** After receipt of the completed application for membership, the Credentials Committee shall make a written report of its investigation to the Medical Executive Committee. Prior to making this report, the Credentials Committee shall examine the evidence of the character, professional competence, qualifications and ethical standing of the Practitioner and other sources available to the Committee, including an appraisal from the Department Chief in which privileges are sought.
- 2.5.9** After receipt of the completed application for membership, the Credentials Committee shall transmit to the Medical Executive Committee the completed application and a recommendation that the Practitioner be either provisionally appointed to the Medical Staff, be rejected for Medical Staff membership, or that the application be deferred for further consideration.
- 2.5.10** The signature of the Chair of the Credentials Committee on the applicable report will indicate the findings and recommendations of the Credentials Committee. If any recommendation is adverse as defined in the Fair Hearing Plan, the provisions of the Fair Hearing Plan will become effective.
- 2.5.11** A summary of the applicant's file, the Department Chiefs and Credentials Committee's findings and recommendations will be forwarded to the Medical Executive Committee at its next regularly scheduled meeting. If the Medical Executive Committee or Board of Trustees' recommendation is adverse as defined in the Fair Hearing Plan, the provisions of the Fair Hearing Plan will control. The Chief of Staff, or designee, will then present the recommendations of the Medical Executive Committee to the Board of Trustees at the next regularly scheduled meeting not to exceed sixty (60) days after the Medical Executive Committee received the Credentials Committee's recommendation.
- 2.5.12** The Medical Staff Office will notify the new appointee of the action of the Board of Trustees within twenty (20) days of the meeting. The signature of the Chief Administrative Officer will indicate approval by the Board of Trustees provisionally

appointing the applicant with specified privileges to the indicated category of the Medical Staff. Any pertinent information regarding appointment to the Medical Staff will be forwarded or made available to the appointee at this time.

2.6 INITIAL APPLICATION CATEGORIES

2.6.1 POLICY: Applications will be categorized by the complexity of the information received. The Department Chief will categorize applications initially.

CATEGORY ONE: A Category One application would be one that is classified as such by the Department Chief in which:

- a. All information is complete;
- b. No adverse information is received from references;
- c. The applicant is in good standing at all current and previous affiliations;
- d. The applicant is a recent graduate from an ACGME approved residency /fellowship program, an APMA approved podiatry program, or an approved ADA/GPR program;
- e. DEA registration is current and unrestricted; (Approved by BOT 9/2/2016)
- f. There is evidence of liability coverage as defined in Section 2.3.2.3 of this policy; and
- g. All references contain no suggestion that the applicant is anything other than highly qualified and capable of exercising good clinical judgment.

CATEGORY TWO: A Category Two application would be one that is classified as such by the Department Chief in which:

- a. The privileges requested do not match the training and/or experience;
- b. The applicant has:
 - 1. Events reported to the NPDB or there is knowledge of an event in the process of being reported;
 - 2. gaps in the application history;
 - 3. voluntary or involuntary relinquishment of any license or registration;
 - 4. poor letters of recommendation;
 - 5. an adverse final judgment in a professional liability action any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment or settlements against the applicant;
 - 6. voluntary or involuntary termination of medical staff membership;
 - 7. withdrawal of application at another facility;
 - 8. voluntary or involuntary limitation, reduction, denial or loss of clinical privileges;
 - 9. current or previously successful challenge to licensure or DEA registration; or
 - 10. Disclosure of a history of physician impairment (alcohol, drug, behavioral, physical, or mental). (Approved by BOT September 28, 2016)
- c. There is any adverse information not previously outlined.

A change of category can be recommended by the Credentials Committee or the Medical Executive Committee in the review process.

2.6.2 PROCEDURE FOR PROCESSING CATEGORIES

CATEGORY ONE: The application is reviewed by the Department Chief and classified as a Category One.

Only Category One designated applications are considered for

- Temporary privileges pending completion of the Committee review process, and
- expedited processing.

CATEGORY TWO: The application is reviewed by the Department Chief and classified as a Category Two. The Department Chief's recommendation is forwarded to the Credentials Committee for their consideration. Following receipt of all information required to be submitted by the applicant pursuant to these Bylaws, the Credentials Committee has the option to conduct an in-depth interview with the applicant. At its discretion, the Committee may require the applicant to be subject to such an interview by the Department Chief and/or Credentials Chairman. The interview results must be documented and placed in the applicant's file. The Credentials Committee will forward its recommendation to MEC for consideration. MEC will review the application at its next regularly scheduled meeting and forward a recommendation to the Board of Trustees.

2.7 DEPARTMENT CHIEFS REPORT

- 2.7.1 DEFERRAL:** Department Chiefs may not defer consideration of an application. A report must be forwarded to the Credentials Committee within thirty (30) days. In the event a Chair does not formulate a report for any reason within thirty (30) days, the application will be forwarded directly to the Credentials Committee.
- 2.7.2 FAVORABLE FINDINGS:** Department Chiefs must document their findings pertaining to adequacy of education, training and experience for all privileges requested. Reference to any criteria for privilege review must be documented. Specific reference to the credentials file should be made in support of all findings.
- 2.7.3 UNFAVORABLE FINDINGS:** Department Chiefs must document the rationale for all unfavorable findings. Reference to any criteria for clinical privileges that is not met should be documented.

2.8 CREDENTIALS COMMITTEE ACTION

- 2.8.1 DEFERRAL:** Action by the Credentials Committee to defer the application for further consideration must be followed up at the next meeting to discuss approval or denial of, or any special limitations to, staff appointment, category of staff and prerogatives, department affiliations, and scope of clinical privileges. The Chair of the Credentials Committee shall promptly send the applicant written notice of an action to defer.
- 2.8.2 FAVORABLE RECOMMENDATION:** When the Credentials Committee's recommendation is favorable to the applicant in all respects, it shall promptly forward, together with all supporting documentation, to the MEC. All supporting documentation includes the application form and its accompanying information, the reports and recommendations of the Department Chief and comments by the Credentials Committee, if any, as well as all dissenting views.

- 2.8.3 ADVERSE RECOMMENDATION:** An adverse recommendation by the Credentials Committee is defined as a recommendation to deny appointment, or to deny or restrict requested privileges. The Credentials Committee must document their rationale for all unfavorable findings and forward it to the MEC together with all supporting documentation.
- 2.8.4** Within sixty (60) days after the receipt of the completed application for membership, the Credentials Committee shall make a written report of its recommendations to the MEC. This time period may be extended, if necessary in order for the Committee to obtain and review information concerning the applicant's qualifications but is not to exceed ninety (90) total days. In any case, where such extension is for more than an additional sixty (60) days, the Credentials Committee shall file a written report with MEC indicating the reason(s) why the Credentials Committee has been unable to approve its investigation during such period.

2.9 MEDICAL EXECUTIVE COMMITTEE ACTION

- 2.9.1** After receipt of the Credentials Committee's report and recommendations, the MEC, at its next regular meeting, shall consider the report. The MEC shall make specific finding as to the applicant's satisfaction of the requirements of experience, ability, and current competence as set forth herein. The MEC will make a written report of its investigation to the Trustees, including its recommendation that the applicant be appointed to the provisional staff, rejected or that the application is deferred for further consideration.
- 2.9.2 DEFERRAL:** MEC may also defer action on the application. When the recommendation of MEC is to defer the application for further consideration, it must be followed up at the next meeting, but in no event greater than thirty (30) days from the deferral, with a subsequent recommendation for provisional appointment with specified clinical privileges, or for rejection of staff membership. The reasons for each recommendation shall be stated and supported by reference to the completed application and all other documentation considered by MEC, all of which will be transmitted with the report to the trustees. Any minority views shall also be reduced to writing, supported by reasons and references, and transmitted with the majority report.
- 2.9.3 FAVORABLE RECOMMENDATION:** If the recommendation of the MEC is for appointment to the provisional staff, the Chief of Staff shall forward its recommendation, including recommended clinical privileges, which may be qualified by probationary conditions where appropriate, to the Board of Trustees. Favorable Category 1 recommendations are eligible for expedited processing. The recommendation of MEC shall be forwarded to the Chief Administrative Officer and the Chairman of the Board of Trustees who may act on behalf of the Trustees in an expedited manner. An informational report to the Board of Trustees will be made at the next regularly scheduled meeting where the approvals will be ratified.
- 2.9.4 ADVERSE RECOMENDATION:** When the recommendation of MEC is adverse to the applicant either in respect to appointment or clinical privileges, the Chief of Staff shall promptly notify the applicant by certified mail, return receipt requested. No such adverse recommendation need be forwarded to the

Trustees until after the applicant has exercised or has been deemed to waive his right to mediation as provided in the Medical Staff Bylaws, Section 5.5 or a hearing as provided in the Fair Hearing Plan in these bylaws.

2.10 APPLICATION AFTER ADVERSE APPOINTMENT DECISION

An applicant who has received a final adverse decision regarding appointment shall not be considered for application to the Hendrick Medical Center Brownwood Staff for a period of one year after notice of such decision is sent, or until the defect constituting the grounds for the adverse action is corrected, whichever is later.

2.11 TIME PERIODS FOR PROCESSING

All individuals and groups required to act on an application for staff appointment must do so in a timely and good faith manner and, except for good cause, each application should be processed within the time periods stated elsewhere in this manual, unless the practitioner has failed to provide requested information needed to complete the verification process.

2.12 DENIAL FOR HOSPITAL'S INABILITY TO ACCOMMODATE APPLICANT

A decision by the Board to deny staff membership, staff category assignment or particular clinical privileges based on any of the following criteria shall not be deemed to be adverse and shall not entitle the applicant to the procedural right provided in the Fair Hearing Plan: (1) On the basis of the hospital's present inability to provide adequate facilities or supportive services for the applicant and his/her patients as supported by documented evidence; (2) On the basis of inconsistency with the hospital's current services plan, including duly approved privileging criteria and mix of patient services to be provided; or (3) On the basis of professional contracts the hospital has entered into for the rendition of services within various specialties.

ARTICLE 3: REAPPOINTMENT

3.1 INFORMATION COLLECTION AND VERIFICATION

3.1.1 Each member of the staff, except for provisional staff members, becomes eligible for reappointment every two years. The Medical Staff Office, at least one hundred twenty (120) days prior to the expiration date of the present staff appointment, shall provide each staff appointee with a reappointment application. Each staff appointee who desires reappointment shall return his reappointment application to the Medical Staff Office within thirty (30) days of receipt. The appointee must furnish in writing:

3.1.1.1 Complete information to update his file on items listed in the original application;

3.1.1.2 Specific requests for the clinical privileges sought on reappointment, with any basis for changes;

3.1.1.3 Requests for changes in staff category or department assignments;

3.1.1.4 Continuing training, education, and experience during the preceding appointment period that qualifies the staff member for the privileges sought on reappointment;

3.1.1.5 Current licensure and any information relating to previously successful or currently pending challenges;

3.1.1.6 Current physical and mental health status only to the extent necessary to determine the practitioner's ability to perform the functions of staff membership or to exercise the privileges requested;

3.1.1.7 The name and address of any other health care organization or practice setting where the staff member provided clinical services during the preceding appointment period;

3.1.1.8 Details about filed, pending, settled, or litigated malpractice claims and suits during the preceding appointment period;

3.1.1.9 Information as to whether the applicant has current in force professional liability coverage meeting the requirements of these Bylaws. Each practitioner must, at all times, keep the MEC informed of changes in his/her professional liability coverage;

3.1.1.10 Information as to previously successful or currently pending challenges to, or the voluntarily relinquishment of, any of the following during the preceding appointment period: (1) license to practice any profession in any jurisdiction; (2) Drug Enforcement Agency (DEA) number/controlled substance license (except pathologists); (3) Medical Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges; (4) the practitioner's management of patients which may have given rise to investigation by the state medical board; (5) participation in any federal or state health insurance program, including Medicare or Medicaid; (Revised/ Approval by BOT 2/24/2016)

- 3.1.1.11** At the request of the Credentials Committee, the MEC, or the Board, when based on the opinion of the same, there is insufficient data concerning the applicant's exercise of privileges in this Hospital during the preceding term of appointment to base a reasonable evaluation, the names of at least three (3) practicing colleagues who have worked with the applicant within the past two (2) years and personally observed his/her professional performance and who are able to provide knowledgeable peer recommendations as to applicant's education, relevant training and experience, clinical ability and current competence, ethical character and ability to exercise the privileges requested and to work with others;
- 3.1.1.12** Each Medical Staff member shall attest to completing CME in accordance with the Texas State Board of Medical Examiners and will provide copies of documents upon request, and
- 3.1.1.13** Failure to obtain board certification within the required timeframe may for initial appointment result in termination of privileges. (Revised and Approval by BOT 2/24/2016)

Failure, without good cause, to provide this information is deemed a voluntary resignation from the staff and automatically results in expiration of appointment unless explicitly extended for not more than two 30-day periods by action of the Credentials Committee. The staff appointee then has the burden of producing adequate information and resolving any doubt about the data.

- 3.1.2** All returned documents should be reviewed and verified as described in the INITIAL APPOINTMENT AND PROCEDURE.
- 3.1.3** Appraisal for reappointment to the medical staff or renewal or revision of clinical privileges is based on but not limited to ongoing monitoring of information concerning the individual's:
- 3.1.3.1** Professional Performance (Ongoing Professional Practice Review); Such evidence shall include as the results of the applicant's ongoing practice review, including data comparison to peers, core measures, outcomes, and focused review outcomes during the prior period of appointment. Practitioners who have not actively practiced in this Hospital during the prior appointment period will have the burden of providing evidence of the practitioner's professional practice review, volumes and outcomes from organization that currently privilege the applicant and where the applicant has actively practiced during the prior period of appointment.
- 3.1.3.2** Judgment; and
- 3.1.3.3** Clinical or Technical Skills.

The Medical Staff Coordinator or appropriate administrative representative will compile a summary of clinical activities for each appointee due for reappointment.

3.2 PROCEDURE FOR APPLICATIONS FOR STAFF PROCESSING REAPPOINTMENT

3.2.1 POLICY: Applications will be categorized by the complexity of the information received. The Department Chief will categorize applications initially.

CATEGORY ONE: A Category One application would be one that is classified as such by the Department Chief in which the applicant:

- a. Is well known to the Medical Staff;
- b. Has a current license, DEA certification;(Approved by BOT September 28, 2016)
- c. Has evidence of liability coverage as defined in Section 2.3.2.3 of this policy;
- d. Does not request an increase in privileges;
- e. Has provided all information requested and completed the application form;
- f. Has no unusual quality events identified in the profile since the last reappointment; and

CATEGORY TWO: A Category Two application would be one that is classified as such by the Department Chief in which since the last appointment:

- a. The privileges requested do not match the training and/or experience;
- b. The physician's profile contains questionable quality events including but not limited to;
 1. events reported to the NPDB since the last appointment or there is knowledge of an event in the process of being reported;
 2. poor letters of recommendation;
 3. pending malpractice claims or adverse final judgment in a professional liability action;
 4. voluntary or involuntary termination of medical staff membership at another facility;
 5. withdrawal of application at another facility;
 6. voluntary or involuntary limitation, reduction, denial or loss of clinical privileges;
 7. current challenge to licensure or DEA registration; (Approved by BOT September 28, 2016)
 8. voluntary or involuntary relinquishment of any license or registration; or
 9. disclosure of a history of physician of impairment (alcohol, drug, behavioral, physical, or mental)

A change of category can be recommended by either the Credentials Committee or the Medical Executive Committee in the review process.

3.2.2 PROCEDURE FOR PROCESSING CATEGORIES

CATEGORY ONE: The application is reviewed by the Department Chief and classified as a Category One. The application is forwarded to the Credentials Committee for review. The application is forwarded to the Medical Executive Committee for review and recommendation to the Board of Trustees. Following a positive recommendation from the MEC, the application is forwarded to the Chief Administrative Officer and the Chairman of the Board of Trustees who may act on behalf of the Trustees in an expedited manner.

An informational report to the Board of Trustees will be made at the next regularly scheduled meeting where the approvals will be ratified. If any of the above credentialing representatives feel uncomfortable signing for approval, the application will automatically advance to Category Two.

CATEGORY TWO: The application is reviewed by the Department Chief and

classified as a Category Two. The application is forwarded to the Credentials Committee for review. The Medical Executive Committee will review the application at its next regularly scheduled meeting and forward a recommendation to the Board of Trustees.

If the decision of the Trustees is adverse to an applicant, the matter is referred back to the MEC for further evaluation.

An applicant is usually ineligible for the expedited process related to a Category One designation, if any of the following has occurred since the time of reappointment:

- The MEC makes a final recommendation that is adverse or with limitations;
- There is a current challenge to licensure or registration;
- The applicant has received an involuntary termination of Medical Staff membership at another healthcare facility;
- The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges; or
- There is an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

3.2.3 REQUEST FOR Modifications OF APPOINTMENT STATUS OR PRIVILEGES

A staff appointee, either in connection with reappointment or at any other time, may request modification of his staff category or clinical privileges by submitting a written request to the Credentials Committee on the approved form attached to this policy. The request is processed in the same manner as a reappointment. All requests for increased privileges must be accompanied by information demonstrating current clinical competence in the specific privilege requested. Such a request may not be filed within six (6) months of the time that a similar request has been denied.

3.2.4 PROCESSING: If the recommendation of the Medical Executive Committee is adverse to the applicant, in whole or in part, the procedure adopted for adverse recommendations on initial applications will be followed. The applicant will be sent a notice complying with the requirements of Notice of Adverse Action or Recommendation set forth in the Bylaws and the adverse recommendation will be held pending request for mediation as provided in the Medical Staff Bylaws, Section 5.5, request for hearing or waiver of hearing rights.

3.2.5 MEDICAL EXECUTIVE COMMITTEE: Except in the case of Practitioners for whom there is an adverse recommendation on reappointment, the Medical Executive Committee shall make its written recommendation to the Board of Trustees through the Chief of Staff concerning the reappointment and/or clinical privileges of each Practitioner.

3.2.6 TIME PERIODS FOR PROCESSING: Transmittal of the reappointment application to an appointee and the return of application shall be carried out in accordance with Section 3.1.1. Thereafter and except for good cause, each person, department and committee required by these Bylaws to act thereon shall complete such action in timely fashion. All reports and recommendations concerning the reappointment of an appointee shall be transmitted to the Medical Executive Committee for its consideration and action and to the Board of Trustees for its action prior to the expiration date of the Staff appointment of the appointee being considered.

3.3 MEDICAL RECORDS DELINQUENCY RATES

3.3.1 REQUIREMET: If an applicant for reappointment has an average monthly medical record delinquency rate, as defined below, equal to or in excess of ten percent (10%) for the twenty-four (24) months immediately preceding the filing of the reappointment application, the applicant may not be reappointed for more than twelve (12) months and shall be placed on probation for the term of the reappointment.

If the applicant does not reduce the medical record delinquency rate below an average of ten percent (10%) for the period of reappointment, the applicant shall not be eligible to apply for reappointment and may not apply for reappointment for a period of at least twelve (12) months. This action would entitle the physician to the procedural rights provided in the Fair Hearing Plan (Appendix A).

3.3.2 DEFINED: The medical record delinquency rate is the percentage of the Practitioner's medical records for which the

- a. history and physical examination,
- b. operative report,
- c. final diagnosis,
- d. discharge summary, or
- e. signature/authentication

did not meet the time standards set out in the Rules and Regulations, "Delinquency of the Medical Record."

The monthly delinquency rate is defined as the number of delinquencies of a given type divided by the number of opportunities for delinquency.

The average monthly medical record delinquency rate is defined as the sum of the monthly rates divided by the number of months.

The rate is equal to or in excess of 10% for any one of the five (5) elements and is not a combined rate.

3.3.3 NOTICE OF RATE: Practitioners will be notified on at least a quarterly basis of their medical record delinquency rates.

3.3.4 AUTOMATIC: The provision for probation and the prohibitions on reappointment in excess of twelve (12) months are automatic and do not entitle the applicant or physician/practitioner to any procedural right of review under the Medical Staff Bylaws or otherwise. These provisions are in addition to and not in limitation of any other procedures or sanctions set forth in the Medical Staff Bylaws, the Credentialing Policies, or the Rules and Regulations.

ARTICLE 4: CLINICAL PRIVILEGES

4.1 EXERCISE OF PRIVILEGES

Every physician or other professional practicing at this hospital, by virtue of medical staff membership or otherwise, may exercise only those privileges granted to him/her by the Board of Trustees or emergency privileges as described herein.

4.2 PRIVILEGES IN GENERAL

4.2.1 EXERCISE OF PRIVILEGES: Except as otherwise provided in these Bylaws, said privileges and services must be hospital specific; within the scope of any license, certificate, or other legal credential authorizing practice in the state of Texas and consistent with any restrictions thereon.

4.2.2 BASIS FOR PRIVILEGES DETERMINATION: Requests for clinical privileges will be considered only when accompanied by supporting documentation of education, training, experience and demonstrated competence as specified by the hospital. In the event a request is submitted for which no criteria have been created, the request will be tabled for a reasonable period of time during which the Board of Trustees will, after consultation with the Credentials and Medical Executive Committees, formulate the necessary criteria with input from the Medical Staff. Once objective criteria have been established, the original request will be processed as described herein.

Valid requests for clinical privileges will be evaluated on the basis of education, training, experience, demonstrated competence, ability and judgment, as well as community and hospital need, available facilities, equipment and number of qualified support personnel and resources. The basis for privileges determination to be made in connection with periodic reappointment or a requested change in privileges must include observed clinical performance and documented results of the staffs' quality improvement program activities. Privilege determinations will also be based on pertinent information from other sources, especially other institutions and health care settings where the professional exercises clinical privileges, including the information specified in Section 3.1.3. The information will be added to and maintained in the Medical Staff file established for the staff appointee. In addition, those practitioners seeking new, additional or renewed clinical privileges (except those seeking emergency privileges) must meet all criteria for Medical Staff membership as described herein, including a query of the National Practitioner Data Bank.

4.2.3 Podiatrists

Privileges granted to podiatrists shall be based on their training, experience and demonstrated competence and judgment. The scope and extent of surgical privileges that each podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Consistent with the clinical privileges granted, podiatrists may admit and perform full histories and physicals for any podiatric admissions. However, podiatrists may not perform full histories and physicals for patients who are not undergoing podiatric medical treatment. If inpatient admission becomes necessary for non-podiatric medical treatment, the patient will be transferred to the Hospitalist service or a physician who can provide inpatient evaluation and care.

4.2.4 Dentists

Privileges granted to dentists shall be based on their training, experience and demonstrated competence and judgment. The scope and extent of surgical privileges that each dentist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. All dental patients (except patients of Oral Surgeons) shall be co-admitted by a physician member of the Active Medical Staff and shall receive the same basic medical appraisal as patients admitted for other surgical services. A physician member of the Active Medical Staff shall be responsible for the care of any medical problem that may be presented at the time of admission or that may arise during hospitalization.

4.3 REVIEW OF CLINICAL PRIVILEGES

4.3.1 Biannual or annual determination of privileges and the increase or curtailment of same shall be based upon the applicant's training, experience and demonstrated competence, which shall be evaluated by review of the applicant's credentials, direct observation by the active staff and review of records, or any portion thereof, of patients treated in this or other hospitals.

4.3.2 In order to obtain additional clinical privileges, any member of the staff shall make written application on the approved form stating the type of privileges desired and furnish evidence to establish competency and qualifications for such privileges. Such application shall be presented to the Department Chief.

4.3.3 A staff member may voluntarily relinquish specific clinical privileges without penalty at any time, providing no disciplinary action is pending.

4.3.4 The Credentials Committee, for re-evaluation of privileges, may interview any staff member whose practice has been interrupted for a period of one hundred twenty (120) days or more by reason of disability.

4.3.5 Termination of a member from an administrative position within the hospital shall not result in a reduction in clinical privileges without waiver or exercise of the procedural rights set forth in the Fair Hearing Plan.

4.4 TEMPORARY PRIVILEGES

4.4.1 Temporary privileges may only be granted when there is an emergency patient care need that mandates an immediate authorization to practice, for a limited period of time, while full credentials information is verified and approved. The applicant must be an appropriately licensed Practitioner. The applicant must have

- A complete application,
- No current or previously successful challenge to licensure or registration,
- Not been subject to involuntary termination of medical staff membership at another organization, and
- Not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges.

The CAO, or his designee, shall verify appropriate information regarding the individual's

- ♦ Current licensure and DEA registration,

- ◆ Relevant training or experience,
- ◆ Current clinical competence and judgment,
- ◆ Character, ethical standing, behavior,
- ◆ Ability to safely and competently exercise the privileges requested,
- ◆ Professional liability insurance coverage,

The results of the Data Bank query and/or any information otherwise received from the Data Bank, and the OIG have been obtained and evaluated before making a final decision to grant temporary privileges.

4.4.2 The applicant shall act under the supervision of the Chief of Staff who may impose special requirements of consultation and reporting. Prior to granting temporary privileges the individual must agree in writing to abide by the bylaws, rules and regulations and policies of the medical staff and the hospital in all matters relating to his temporary privileges. Whether such written agreement is obtained, these Bylaws and policies control all matters relating to the exercise of clinical privileges.

4.4.3 Temporary privileges must be granted for a specific period of time as warranted by the situation and may not exceed one hundred twenty (120) days. An extension may be granted upon the recommendation of MEC.

4.4.4 CIRCUMSTANCES

Upon written concurrence of the Department Chair where the privileges will be exercised or the Chief of Staff, the Chief Administrative Officer, or designee, may grant temporary privileges for the following provided that there is an important patient care need that requires immediate authorization to practice:

4.4.4.1 Specific Patient- Following the procedures in this Article, at the request of the attending physician, temporary clinical privileges may be granted for the care of a specific patient to a physician, dentist or podiatrist who is not an applicant for membership to the medical staff. The Practitioner must be a member in good standing of the active staff of another Joint Commission accredited or Medicare approved hospital, and is exercising the privileges he requests at such other hospital. Such privileges are intended for isolated instances in which extension of such privileges are shown to be in an individual patient's best interest, and no practitioner shall be granted one-case privileges on more than five (5) occasions in any given year. The attending physician must co-sign all orders.

4.4.4.2 Locum Tenens Following the procedures in this Article, temporary privileges may be granted to a person for the purpose of serving as a locum tenens for a current member of the Medical Staff. Such person may attend only patients of the member(s) for whom he/she is providing coverage. Upon receipt of written request, an appropriately licensed person who is serving as locum tenens for a member of the Medical Staff may, without applying for membership on the staff, be granted temporary privileges for an initial period not to exceed thirty (30) days. Such privileges may be renewed for successive consecutive periods not to exceed thirty (30) days, but only upon the

practitioner establishing his/her qualifications to the satisfaction of the MEC and the Board and in no event to exceed one hundred twenty (120) days of service as locum tenens within a calendar year. All physicians providing coverage through such locum tenens services must ensure that all legal requirements, including billing and reimbursement regulations are met. The Data Bank query must be completed prior to any award of locum tenens privileges pursuant to this section. Further, prior to award of locum tenens privileges the applicant must submit a completed application, a photograph, proof of appropriate malpractice insurance, the consent and release required by these bylaws, copies of the practitioner's license to practice medicine, DEA certificate and telephone confirmation of privileges at the practitioner's primary hospital. The letter approving locum tenens privileges shall identify the specific privileges granted. Members of the Medical Staff seeking to provide coverage through locum tenens physicians shall advise the Hospital at least sixty (60) days in advance of the identity of the locum tenens and the dates during which the locum tenens services will be utilized in order to allow adequate time for appropriate verifications to be completed.

4.4.4.3 Proctoring or Teaching- Upon receipt of an application for temporary privileges from an appropriately licensed Practitioner and verification of such applicant's qualifications and credentials to teach or learn specific clinical procedures, the Chief Administrative Officer, upon the written concurrence of the Chief of Staff, may grant temporary clinical privileges to a Practitioner for the purpose of teaching or learning specific clinical procedures.

4.4.4.4 Pending Application-Temporary privileges may not be granted pending processing of applications for appointment or reappointment.

4.4.4.5 Emergency Privileges- In case of an emergency, any Medical Staff appointee with clinical privileges is "temporarily privileged" to provide any type of patient care necessary to save the patient's life or to save the patient from serious harm, to the degree permitted by the appointee's license regardless of department affiliation, staff category or level of privileges. A Practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and arrange appropriate follow-up.

When an emergency situation no longer exists, such medical staff member must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or he does not desire to request privileges, the patient shall be assigned to an appropriate medical staff member.

For the purpose of this section, an "emergency" is defined as a condition in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

4.4.4.6 Disaster Privileges- During disaster(s) in which the Disaster Response Procedure has been activated and if necessary to provide immediate patient care needs, the Chief of Staff or the CAO or their designee(s) may grant emergency privileges as outlined in the Disaster Credentialing Policy maintained with the Medical Staff Policies.

4.5 TERMINATION OF TEMPORARY PRIVILEGES

4.5.1 Temporary privileges shall expire at the end of the time period for which they were granted, or

4.5.2 The Chief of Staff or the Chief Administrative Officer, after consultation with the appropriate Department Chair, may terminate any or all of a Practitioner's temporary privileges on the discovery of any information or the occurrence of any event which raises questions about a Practitioner's professional qualifications or ability to exercise any or all of the temporary privileges granted. Where it is determined that the life or health of such patient(s) would be endangered by continued treatment by the physician, the termination may be imposed by any person entitled to impose summary suspension under the Medical Staff Bylaws. In the event of any such termination, the Chief of Staff or in his absence, the Vice-Chief of Staff, shall assign a member of the medical staff to assume responsibility for the care of such terminated physician's patient(s) until they are discharged from the hospital. The wishes of the patient shall be considered, when feasible, in choosing a substitute Practitioner.

4.6 RIGHTS OF THE PRACTITIONER WITH TEMPORARY PRIVILEGES

A Practitioner is not entitled to the procedural rights afforded by the Fair Hearing Plan because his request for temporary privileges is refused or because all or any part of his temporary privileges are terminated or suspended.

ARTICLE 5: PRACTITIONER PROVIDING CONTRACTUAL SERVICES

5.1 EXCLUSIVE POLICY

Whenever hospital policy specifies that certain hospital facilities or services may be used on the exclusive basis in accordance with the contracts or letters of agreement between the hospital and qualified Practitioners, then other staff appointees must, except in an emergency or life-threatening situation, adhere to this exclusivity policy in arranging care for their patients. Application for initial appointment or for clinical privileges related to hospital facilities or services covered by exclusivity agreements will not be accepted or processed unless submitted in accordance with the existing contract or agreement with the hospital.

5.2 QUALIFICATIONS

A Practitioner who is or will be providing specified professional services pursuant to a contract or letter of agreement with the hospital must meet the same qualifications, must be processed in the same manner, and must fulfill all the obligations of his appointment category as any other applicant or staff appointee.

5.3 EFFECT OF STAFF APPOINTMENT TERMINATION

Because practice at the hospital is always contingent upon continued staff appointment and is also constrained by the extent of clinical privileges enjoyed, a Practitioner's right to use hospital facilities is automatically terminated when his staff appointment expires or is terminated. Similarly, the extent of his clinical privileges is automatically limited to the extent the pertinent clinical privileges are diminished.

5.4 EFFECT OF CONTRACT EXPIRATION OR TERMINATION

The effect of expiration or other termination of a contract upon a Practitioner's staff appointment and clinical privileges will be governed solely by the terms of the Practitioner's contract with the hospital. If the contract is silent on the matter, then contract expiration or other termination alone will not affect the Practitioner's staff appointment status or clinical privileges.

ARTICLE 6: TELEMEDICINE

6.1 SCOPE OF PRIVILEGES

The Medical Staff shall make recommendations to the Board of Trustees regarding which clinical services are appropriately delivered through the medium of telemedicine and the scope of such services. Clinical services offered through this means shall be provided consistent with commonly accepted quality standards.

6.2 TELEMEDICINE PHYSICIANS

Any physician who prescribes, renders a diagnosis, or otherwise provides clinical treatment to a patient at the Hospital through a telemedicine procedure (the telemedicine physician), must be credentialed and privileged through the Medical Staff pursuant to the credentialing and privileging procedures described in these Medical Staff Bylaws.

6.2.1 An exception is outlined below for those circumstances in which the practitioner's distant-site entity or distant-site hospital is Joint Commission accredited and the Hospital Places in the practitioner's credentialing file a copy of written documentation confirming such accreditation. In circumstances in which the distant-site entity or hospital is Joint Commission accredited, the Medical Staff and Board may rely on the telemedicine physician's credentialing information from the distant-site entity or distant-hospital to credential and privilege the telemedicine physician ONLY if the Hospital has ensured through a written agreement with the distant-site entity or distant-site hospital that all of the following provisions are met:

- 6.2.1.1** The distant-site entity or distant-site hospital meets the requirements of 42 CFR §482.12 (a) (1-7), with regard to the distant-site entity's or distant-site hospital's physicians and practitioners providing telemedicine services;
- 6.2.1.2** The distant-site entity, if not a distant-site hospital, is a contractor of services to the Hospital and as such, in accordance with 42 CFR §482.12 (e), furnishes the contracted services in a manner that permits the Hospital to comply with all applicable federal regulations for the contracted services;
- 6.2.1.3** The distant-site organization is either a Medicare-participating hospital or a distant-site telemedicine entity with medical staff credentialing and privileging processes and standards that at least meet the standards set forth in the CMS Hospital Conditions of Participation;
- 6.2.1.4** The telemedicine physician is privileged at the distant-site entity or distant-site hospital providing telemedicine services, and the distant-site entity or distant-site hospital provides the Hospital with a current list of telemedicine physician's privileges at the distant-site or distant-site hospital;
- 6.2.1.5** The telemedicine physician holds a license issued or recognized by the state in which the Hospital is located; and

- 6.2.1.6** The Hospital has evidence, or will collect evidence, of an internal review of the telemedicine physician's performance of telemedicine privileges at the Hospital and shall send the distant-site entity or distant-site hospital such performance information (including, at a minimum, all adverse events that result from telemedicine services provided by the telemedicine physician and all complaints the Hospital has received about the telemedicine physician) for use in the periodic appraisal of the telemedicine by the distant-site entity or distant-site hospital.

For the purposes of Article 6, the term "distant-site entity" shall mean an entity that: provides telemedicine services; is not a Medicare-participating hospital; and provides contracted services in a manner that enables a hospital using its services to meet all applicable CMS Hospital Conditions of Participation, particularly those related to the credentialing and privileges of physicians providing telemedicine services. For the purposes of Article 6, the term "distant-site hospital" shall mean a Medicare participating hospital that provides telemedicine services. (Added 6.2.1 and Approval by BOT 2/24/2016)

- 6.2.2** If the telemedicine physician's site is also accredited The Joint Commission, and the telemedicine physician is privileged to perform the services and procedures for which privileges are being sought in the Hospital, then the telemedicine physician's credentialing information from that site may be relied upon to credential the telemedicine physician in the Hospital. However, this Hospital will remain responsible for primary source verification of licensure, professional liability insurance, primary Medicare/ Medicaid eligibility and for the query of the Data Bank. (Revised and Approved by BOT 2/24/2016)