Don’t let HCQIA’s discoverability protections pass you by
Peer review documentation best practices

Is the document you just filed in a physician’s confidential peer review file really considered a peer review document? Are you maintaining meeting minutes in such a way that if a physician sues the organization, he or she won’t be able to use them against the hospital in a court of law?

The December 2009 case Girraj Bansal v. Mount Carmel Health Systems illustrates just how important it is for medical staffs to appropriately label and maintain peer review documentation to gain immunity under the Health Care Quality Improvement Act (HCQIA). When the plaintiff requested numerous hospital and medical staff documents to support his claims against Mount Carmel, including discrimination and tortuous interference with business and contractual relationships, the organization refused to submit certain documents, claiming that they were protected from discovery.

A trial court didn’t contest the discoverability of the documents that the plaintiff requested. Rather, it assumed that they were protected based on Bansal’s claim. But the Court of Appeals of Ohio Tenth Appellate District found that simply labeling a document “peer review,” “confidential,” or “privileged” doesn’t invoke the statutory privilege. The court ruled that to maintain peer review privilege, a healthcare organization must provide that the documents satisfy the criteria set forth by the state’s peer review statute.

So how do medical staffs maintain peer review documentation that will stand up in court? Follow these tips to keep your documentation practices on the straight and narrow.

Review HCQIA

Medical staffs should ensure that their peer review committees match the definition provided in HCQIA. According to 42 USC Sec. 11151, the term “professional review body” is defined as:

… a healthcare entity and the governing body or any committee of a healthcare entity which conducts professional review activity and includes any committee of the medical staff of such an entity when assisting the governing body in a professional review activity.

The activities of that committee should also meet the definition provided in HCQIA. The law defines peer review activity as an activity of a healthcare entity with respect to an individual physician to:

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Peer review < continued from p. 1

➤ Determine whether the physician may have clinical privileges with respect to, or membership in, the entity
➤ Determine the scope or conditions of such privileges or membership
➤ Change or modify such privileges or membership

Ensuring that your medical staff peer review body and activities meet the definitions of HCQIA better protects documentation produced by a peer review committee from discoverability.

Get familiar with your state’s peer review statute

When deciding whether a document should be classified as peer review, MSPs and medical staff leaders should check their state peer review statutes.

“A lot of states have peer review statutes of their own in addition to the HCQIA statute,” says Annemarie Martin-Boyan, Esq., senior counsel at Temple University Health System in Philadelphia.

For peer review documentation to be legitimately labeled as peer review, ensure that the individuals who sit on their peer review committees meet the definition of a peer (if the statute provides one) and that the activities they engage in match the state’s definition of peer review activities.

The next step is to assess what the state statute defines as peer review documentation. For example, according to The General Laws of Massachusetts, Chapter 111, Section 204, peer review documentation consists of the proceedings, reports, and records of a medical peer review committee. Documents, incident reports, or records otherwise available from original sources (i.e., patient charts) are not protected because they were not generated by the peer review body.

Martin-Boyan says that medical staffs should know their state statutes inside and out. “Not that the federal statute isn’t important, but most cases are tried at the state level,” she says.

Consult your bylaws

The more formalized medical staffs can be with their peer review activities, the better, says Martin-Boyan. With respect to peer review documentation, the bylaws or applicable policies and procedures should explain:

➤ The definition of a peer. According to The Top 40 Medical Staff Policies and Procedures, Fourth Edition, published by HCPro, a peer is “an individual practicing in the same profession who has the expertise to evaluate the subject matter under review. The level of subject matter expertise required will be determined...
on a case-by-case basis.” **Tip:** Some medical staffs take their definitions directly from HCQIA or state law to ensure compliance.

**The purpose of the committee.** Medical staffs can use the following language from *The Top 40 Medical Staff Policies and Procedures* to define the purpose of the peer review committee: “To ensure that the hospital/healthcare organization through the activities of its medical staff assesses the ongoing professional practice evaluation (OPPE) of individuals granted clinical privileges and uses the results of such assessments to improve care and, when necessary, performs focused professional practice evaluation (FPPE).”

**What documents are considered peer review and therefore confidential.** Examples of confidential peer review documents include portions of meeting minutes and other documents generated by the committee for the purposes of assessing a practitioner’s performance, such as the results of the committee’s inquiry into an incident report.

The bylaws or policies and procedures should stipulate that credentialing, quality improvement, and performance improvement activities constitute peer review activities. It should also stipulate that anyone involved in these activities is immune from legal actions regarding their participation on the committee taken against the hospital or individuals by a physician.

**Tip:** Medical staff bylaws should also include guidance for the use of ad hoc peer review committees when delicate circumstances arise, says Martin-Boyan. “When we assemble an ad hoc committee, it is always at the written request of the chair of a designated peer review committee,” she says. “The more formal arrangements you have demonstrating that you intended this to be a peer review activity, the better you’ll fare in court.”

**Ask, ‘What is the purpose of this documentation?’**

“You need to think about whether the documents really are peer review or if they are primary documents that the peer review committee happens to review,” says Terry Rambosek, Esq., of Bennett Bigelow & Leedom in Seattle. For example, the peer review committee references medical records when assessing practitioners’ performance, but a patient’s medical record is not considered a protected peer review document because various committees and individuals must access it in the course of their day-to-day work. An infection rate report is another example of a primary document that is not protected by peer review immunity but is referenced by the peer review committee because it has a broader purpose outside of peer review.

Medical staffs may also need to consider whether all peer review meeting minutes are confidential. Portions of meeting minutes pertaining to peer review discussions, rather than discussions regarding routine committee business, should be designated as peer review documents, says Rambosek. Examples of regular committee business include discussions regarding budgets and purchasing new equipment.

“You can’t just claim that all of the committee minutes are privileged; it is only the part where they are talking about protected information,” Rambosek says.

**Tip:** MSPs responsible for minute-taking may wish to produce a set of meeting minutes with the protected portions redacted after every meeting. This will ensure that protected peer review information stays protected if a plaintiff’s lawyer ever wants to reference them.

“A lot of times, what the courts are referring to protecting is the critical analysis—not the document that states the facts, but the document that is used to analyze what we did, what we should have done, and what we can do better next time,” says Rambosek.

**Keep it confidential**

Medical staffs that fail to keep their peer review documentation confidential may inadvertently waive their right to the peer review protections offered under HCQIA and make what should be undiscoverable documents discoverable. To protect that immunity...
and discoverability, medical staffs and hospitals should adopt a confidentiality of quality improvement information policy, says Rambosek.

Members of the medical staff can ask peer review committee members to sign the policy when first issued and annually thereafter. “People tend to pay attention to things when they have to put their names on it,” says Rambosek.

➤ Hold executive sessions. “Hospitals tend to forget to think about who attends meetings,” Rambosek says. Some meeting attendees may be support personnel or ex officio members. “Make sure your documents clearly indicate who is on the committee, and only those folks should participate in the deliberations that you had meant to be confidential,” she says.

One way to prevent non-voting members from being exposed to privileged information is to hold executive sessions, Martin-Boyan says. Support personnel and ex officio members should be allowed to participate in the routine business portion of the meeting, but they should be excused when discussing peer review issues. Only the voting members should be present for those discussions.

➤ Train, train, train. Rambosek suggests that the following groups receive confidentiality training: employed staff who work in risk management, quality improvement, or peer review; medical staff members; and governing board members.

Frequently, the hospital’s counsel provides this training, held during the first medical staff meeting of the year with invited credentials, bylaws, and medical executive committees, as well as department leaders.

For The Greeley Company’s Credentialing, Confidentiality of Medical Staff Minutes, Quality Improvement, and Peer Review Information policy, visit www.MedicalStaffLeader.com

The following are additional best practices:

➤ Keep documents centrally located. Meeting minutes, applicable policies, and other peer review documents should be kept in a central location, generally with either the chair of the committee or the individual responsible for taking meeting minutes.

➤ Number meeting handouts. Numbering all material packets distributed at peer review committee meetings is a best practice to ensure that no documents leave the room. The chair should dispense the material packets at the beginning of the meeting and collect them at the end, making sure all numbers are accounted for.
‘Pass’ the expiration date

Managing expirables for organization’s sake

Whether you put it at the top of the list or include it as a last-but-not-least, organizational skills are a vital element of an MSP’s work. Those skills sometimes spill out of an MSP’s core job description into projects that help medical staff members.

One example of this is the way MSPs may help practitioners keep track of their expirables, such as medical and DEA licenses. Ultimately, practitioners are responsible for maintaining their own professional licensures.

However, MSPs already keep track of such expiration dates to ensure that practitioners are able to legally provide services at the facility. Therefore, by taking the extra step to remind practitioners when their licenses expire, MSPs can help the practitioners renew their licenses on time and avoid the extra paperwork that comes with re-instating expired medical licenses. (See p. 7 for a sample tracking spreadsheet and more tips about managing expiring documents.)

Scheduling monthly reminders

One way MSPs can remember to remind others to renew expiring licenses is to set up a regularly scheduled time to check expiration dates. Joyce Allen, senior manager of the medical staff services department (MSSD) and library at The Aroostook Medical Center (TAMC) in Presque Isle, ME, says that her organization uses its credentialing software to help track expirables.

“We have an expirables list for things that are licensure related, like [advanced cardiac life support certification (ACLS)] and DEA,” says Allen. “At the beginning of the month, the credentialing coordinator runs that list and sends out e-mail [reminders].”

If a physician is an employee of the organization—which a large percentage are—the physician’s manager is ccc’ed on the e-mail so that all parties are aware of the renewal status.

Tip: Another way to encourage practitioners to renew their licenses on time is to fine practitioners for allowing their licenses to lapse. This may seem redundant when it comes to medical licenses because it’s hitting a practitioner’s wallet twice—once because the practitioner can’t bill for services without a license and twice because of the MSSD fine. However, it can encourage practitioners to renew other licenses as well, such as ACLS.

Nevertheless, Allen says that reminding practitioners can be a double-edged sword because the practitioners may rely on the MSSD to remind them and not track their own licenses. Then, if the MSSD forgets to remind the practitioner to renew, the practitioner could blame the MSSD for allowing the license to lapse.

This is why MSSDs need to emphasize to practitioners that although they will provide the courtesy of reminding practitioners to renew their licenses, it is ultimately the responsibility of the practitioner to maintain current licensure.

At TAMC, the bylaws outline licensure obligations for medical staff members. “On the advice of legal counsel, we put a paragraph in there that says lack of maintaining malpractice insurance and current license [results in] automatic suspension without due process,” says Allen.

For the most part, the message has gotten across to practitioners. Allen says that of TAMC’s 60 active medical staff members and 90 advanced practice professionals, only about three practitioners per year allow their licenses to lapse.

It lapsed, now what?

In some medical staffs, a lapsed license means that a practitioner is no longer eligible to hold privileges and must reapply for privileges. This scenario directly affects the MSSD, but MSPs must remember that there may be other departments that are affected by these changes as well.

Allen says the other departments she notifies depends on what particular license lapsed but typically includes a corporate compliance department and the financial office.

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lapsed Maine license can’t practice medicine in Maine; the practitioner must apply for relicensure, which costs more than the fee for renewing an active license.

Although Maine’s renewal process is unique to Maine, it uses a tiered expiration approach that other states may use. For example, the Tennessee Department of Health sends out an automatically generated reminder 90 days before a practitioner’s license is set to expire, says Elizabeth Miller, director of Health Related Boards at the Tennessee Department of Health. Once the license expires, the practitioner has a 30-day grace period wherein he or she can still renew the license online or by mail.

“At the end of the 30-day grace period, if they try to renew online, they would be unable to do that,” says Miller. “They would have to file a reinstatement application in order to renew the license at that point.”

Like Maine, Tennessee doesn’t notify the practitioner’s hospital or employer that the practitioner didn’t renew his or her license. MSSDs can verify Tennessee licenses online for free or request a written verification for a fee.

In order for a practitioner to qualify for an active Maine medical license, the practitioner must have practiced clinical medicine in the United States and/or territories in the previous 12 months, Sprauge says. Maine also accepts Licentiate of the Medical Council of Canada as a qualifier for licensure.

“So if they are not practicing anywhere and they allow their Maine license to lapse, they risk not being able to practice in Maine again,” says Sprauge.

Most practitioners manage their licenses well and don’t allow them to lapse. According to Sprauge, Maine has about 5,200 licensed practitioners, and about 15 practitioners each month have lapsed licenses. Some of the credit for renewing licenses on time goes to the practitioners, but some of it also goes to credentialing specialists who work with them.

“Credentialers are very diligent in making sure their credentialed providers have current licensure, and that’s a good service to the licensures,” says Sprauge.

Tip: It’s important to notify all relevant parties as soon as possible when a medical license lapses. If a practitioner with an expired medical license is inadvertently practicing medicine and seeing patients, he or she will not be able to bill for those services. Therefore, the hospital will lose money that it could have received if those patients were treated by a practitioner with an active license.

Licensing agency’s perspective

It is helpful for MSPs to know what processes are taking place on the licensing agencies’ side when a license lapses so the MSSD can adjust its processes accordingly. For example, in some states, there may be a grace period between when a medical license lapses and when it officially expires. This date can affect when a practitioner’s privileges officially expire.

Additionally, MSPs should know whether their state medical licensing agency will automatically notify them if a practitioner’s license expires or if the MSP will need to query that information. Medical licensing agencies may also provide best practice to MSSDs about how to issue renewal reminders and notify practitioners.

The Maine Board of Medicine does not directly notify hospitals or other employers when a practitioner fails to renew a license, says Dan Sprauge, MBA, assistant executive director of the Maine Board of Medicine. However, the board adds the information to the public minutes that anyone, including MSPs, can access on the board’s website. Maine medical licenses are valid for two years and expire in the practitioner’s birth month. If the practitioner doesn’t renew the license in time, the board sends the practitioner a renewal card as a reminder. “If they fail to renew, then we send them an administrative suspension letter,” says Sprauge. “It’s not a disciplinary action in any way,” but it does inform the practitioner that he or she has a suspended license and can’t practice on it.

If the practitioner fails to renew the suspended license within 30 days, the license lapses. A practitioner with a lapsed Maine license can’t practice medicine in Maine; the practitioner must apply for relicensure, which costs more than the fee for renewing an active license.

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Sample expiration tracking spread sheet

MSPs are responsible for developing a tracking mechanism for expired credentials. Typically, this is done through a credentialing database. Below is a sample form that MSPs can use to track the various licenses and certifications of each discipline on the medical staff. This chart can be customized to fit your organization’s needs, including meeting state regulations and covering additional certifications, such as DEA certification.

Additionally, MSPs may choose to develop individual tracking spreadsheets for each medical staff member. You can begin the spreadsheet by populating it with any requirements your organization has (e.g., board certification, DEA certification). Then add in any additional certifications that the practitioner holds.

For the sake of simplicity, populate the chart with current certifications and licenses, not ones that the practitioner previously held. Don’t forget to include how long the certifications are valid for (e.g., two years) and the date of expiration (e.g., June 30, 2010).

Finally, consider including insurance and immunization on the expiration tracking sheet. The governing body sets the minimum limits of coverage that physicians and advanced practice professionals are required to maintain. There should not be a grace period for physicians to provide documentation of current coverage that meets these minimum limits. An insurance face sheet is acceptable as long as it lists the practitioner’s name, limits of liability, and effective and expiration dates. As for immunizations, your organization should determine whether it wishes to extend a grace period for practitioners to submit the documentation as well as what documentation is acceptable (e.g., skin test results, x-ray interpretations, a letter from the practitioner’s primary care physician, a health questionnaire). The MSP should also implement a reminder, suspension, and reinstatement process.

<table>
<thead>
<tr>
<th>Discipline</th>
<th>License</th>
<th>Certification 1</th>
<th>Certification 2</th>
<th>Other information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced practice nurse (APN)</td>
<td>APN license RN license</td>
<td>Basic life support (BLS)</td>
<td>American Nurse Credentialing Center (ANCC)</td>
<td>Biennial ANCC CME Requirements</td>
</tr>
<tr>
<td>Audiologist</td>
<td>State license</td>
<td>BLS</td>
<td>American Speech-Language-Hearing Association (ASHA)</td>
<td>ASHA 30-day grace period</td>
</tr>
<tr>
<td>DDS</td>
<td>State dental board</td>
<td>N/A</td>
<td></td>
<td>No grace period</td>
</tr>
<tr>
<td>MD</td>
<td>State medical board</td>
<td>American Board of Medical Specialties</td>
<td></td>
<td>30-day grace period for state licenses</td>
</tr>
<tr>
<td>Perfusionist</td>
<td>State license</td>
<td>BLS</td>
<td>ABCs</td>
<td>No grace period</td>
</tr>
<tr>
<td>Physician assistant</td>
<td>State license</td>
<td>BLS</td>
<td>Physician Assistant-Certified (PA-C)</td>
<td>No grace period</td>
</tr>
<tr>
<td>RN</td>
<td>State license</td>
<td>BLS</td>
<td>Advance cardiac life support</td>
<td>No grace period</td>
</tr>
</tbody>
</table>

Source: The Credentialing Coordinator’s Handbook, by Anne Roberts, CPMSM, CPCS.
Recent court rulings

Quality management documents not privileged

A Colorado judge ordered defendant Craig Hospital to produce certain quality management documents to Karen S. Zander, the plaintiff. Zander claims she became paraplegic after undergoing spinal surgery supervised by Rick Bayles, PhD. Zander sued Bayles and his employer, Craig Hospital, for negligence.

Zander requested that Craig Hospital produce quality management documents, including the risk management plans, safety management policy, Failure Mode and Effects Analysis, and quality/performance improvement plan. Craig Hospital refused, claiming that they were peer review documents protected by the quality assurance privilege.

After reviewing the documents for the first time, the court reversed its prior decision (that the documents were protected) and ordered Craig Hospital to produce the documents.

The quality assurance privilege is designed to promote quality assurance practices by protecting from production information relating to the evaluation or improvement of healthcare services. The court opted for the narrower interpretation of the privilege, concluding that it is the information and data collected for evaluation which is entitled to confidential treatment and which is privileged. Interpreting the privilege to cover quality management program documents at issue here would preclude anyone from ensuring that hospitals complied with their own quality improvement programs.

Source: Zander v. Craig Hospital, Civil Action No. 09-cv-02121-RED-BNB, United States District Court for the District of Colorado. April 9, 2010.

Preliminary injunctions can be used with peer review

The Court of Appeal of the State of California, Fifth Appellate District, has ordered Adventist Health System/West to reinstate plaintiff Brenton R. Smith’s privileges. The order is a preliminary injunction that prevents Adventist from taking further action against Smith until the court can make permanent decisions.

Smith claims that when Adventist failed to purchase his clinics, thus eliminating him as competition, they sought to eliminate him through sham peer review. He claims intentional and unlawful interference with the right to pursue a lawful occupation, intentional interference with prospective business advantage, and unfair competition. The Superior Court ordered Adventist in June 2008 to reinstate Smith’s privileges for one year, at which time he would need to reapply. When Smith reapplied after one year, his application was denied because, as Adventist claims, he failed to follow the medical staff bylaws provision requiring an applicant to wait 36 months following a final adverse decision before reapplying for privileges.

The court found that Smith was likely to win a permanent injunction on the basis that the 36-month waiting period should run from the time of the hospital’s adverse decision rather than the court’s. The balance of harms also favored granting the injunction because denying the injunction would prevent Smith from practicing in the geographic location where his patients reside. The court noted the public interest in avoiding interference with the peer review process but concluded that granting the preliminary injunction would not interfere with that process. The lower court granted the preliminary injunction; the appellate court affirmed.


These cases were reviewed by Bruce Armon, Esq., and Jennifer Beidel, Esq., of Saul Ewing, LLP, in its Philadelphia office. These case summaries are prepared for informational purposes only and should not be considered legal advice.