Review, update, and follow credentialing policies & bylaws to protect against malpractice claims

Don’t let essential documents gather dust

Despite their best intentions, practitioners do make mistakes, which can lead to malpractice lawsuits filed by patients and their families.

Frequently, hospitals are also roped into these cases through claims of corporate negligence or negligent credentialing. The majority of states have instituted caps on medical malpractice claims, meaning more plaintiff attorneys are going after the deeper pockets of the medical facility with claims of negligence.

Every month, legal cases implicating hospitals for a practitioner’s actions (or inaction) show up in the headlines. But hospitals can insulate themselves from these claims by adopting policies and bylaws that fall in line with national standards, and then following those bylaws to the letter. These straightforward steps help ensure the organization is privileging competent and trained physicians.

“The way I approach it is, did the hospital deviate from a standard of care in credentialing,” says Jeff Moseley, partner at Buerger, Moseley, and Carson, PLC, in Franklin, Tenn. “Doctors make mistakes and they are going to get sued. The question is, did we know or should we have known something and still granted the privileges or still reappointed them.”

But a few simple steps can save hospitals a lot of time spent in the courtroom and money spent on settlements to plaintiffs.

Review policies and bylaws

It’s imperative that hospitals base their policies and medical staff bylaws on national standards from The Joint Commission and CMS, and relevant specialty organizations.

These policies should be reviewed on an annual basis for two reasons. First, national standards can change, and you need to align your bylaws with those changes. Secondly, procedures and credentialing requirements may change within your own institution periodically, and if your documented procedures do not fall in line with your bylaws, you could open yourself up to negligence liability.

“The bylaws need to accurately reflect the credentialing process, what standard they are following, and what they are doing,” Moseley says. “To me, that is probably the No. 1 offender in negligent credentialing cases.”

It’s common for the medical staff to either ignore its annual policy review or breeze over it without a thorough look, says Samuel Steinberg, PhD, FACHE.
consultant with S.H. Steinberg Consulting, LLC, in Daytona Beach, Fla.

“Too often the policies were really written years ago,” he says. “Many hospitals still ... take an old policy and put a new review date on it. If you have ever looked at these things, you look at the bottoms and it says, ‘Reviewed in 2001, 2002, 2003,’ and you’re just telling any lawyer that this hasn’t been a substantive review process.”

Unfortunately, many physicians view the bylaws as something to be pulled down from the shelf every two years, updated, and then put back on the shelf to be forgotten, Moseley says. In some instances, hospitals will need to undergo a culture change so physicians understand the importance of this review.

The annual review should involve multiple members of the medical staff, as well as representatives from the board and the medical executive committee (MEC). Steinberg recommends including at least one member of the board of trustees who is knowledgeable about medical malpractice claims. Having these people at the table sends the message that quality and safety are serious considerations.

“I also like to see staff nurses at the table,” Steinberg says. “People who may be directly involved in the type of case, but also people who are leaders, who are knowledgeable and confident enough to speak their minds.”

Reviewing policies and bylaws on an annual basis allows hospitals to look at issues prospectively rather than retrospectively, when it’s too late to go back and change your approach.

“The primary problem that I see is that more often than not, all of the analysis that takes place is retrospective,” Steinberg says. “Hospital risk managers and sometimes legal counsel are always looking back. They find out about a case and to a certain extent the horse is out of the barn already.”

**Follow the bylaws**

The second crucial step in protecting your facility from malpractice liability is clearly following your written bylaws to the letter, Moseley says.

For example, if your bylaws state that a cardiac surgeon needs to be board certified, yet the organization grants privileges to a cardiac surgeon who doesn’t have board certification, it will be a red flag to the plaintiff’s attorney that the organization is not following its prescribed procedures.

“You need to have bylaws and policies that reflect a good credentialing process, and you need to follow them,” Moseley says. “That’s the second area where you can get in trouble. You can have this great policy here but you’re not following it. That’s where we see the biggest exposure now.”

To help ensure policies and bylaws are followed, it is essential to orient the entire medical staff to these...
documents. Steinberg says that too often hospitals simply hand new medical staff members a manual, accept a signed document that states the physician read and understood the manual, and expect a similar document sometime down the road that states the physician reviewed the updated manual. Sometimes these staff members are deposed in court and have to testify that they only saw the policies once or twice, which creates huge legal implications for the hospital.

**Avoid favoritism**

A common problem among hospital MECs is the tendency to mix politics and friendships into the credentialing process. This can be a haven for negligence liability if a plaintiff’s attorney can prove there was some form of favoritism toward particular physicians that resulted in overlooking certain bylaws or standards.

“Some hospitals allow the credentialing committee to be a part of the ‘old boy’ network,” Steinberg says. “The fact that you’ve worked with someone, that’s not a substitute for data. It can be an inside or outside perspective, but it sure has to be objective and it has to be data driven.”

Some hospitals can benefit from bringing in an outside consultant to review their processes and ensure they are approaching the credentialing process fairly.

It’s easier to avoid conflicts of interest for initial applicants because they have not yet formed many relationships and they are judged by what is on their application. Hospitals get into legal trouble when they start requiring less data from a physician just because he has been on staff for 25 years and everyone knows him. The court system will still find the organization negligent if it fails to follow its bylaws explicitly.

“You simply can’t have selective enforcement of your provisions,” Moseley says.

**Make sure the application is complete**

It sounds simple, but many hospitals still overlook the fact that every part of the application needs to be completed and verified before a physician can be granted privileges, Moseley says.

Sometimes hospitals will have all the necessary information with the exception of something like insurance history. If everything else meets the stated requirements, the physician applicant might be granted medical staff membership and privileges pending receipt of his or her insurance history. However, if that physician has the proper privileges and something goes wrong, the hospital could be partially to blame for accepting an incomplete application.

Furthermore, after granting privileges, the MEC might discover malpractice cases in the physician’s history that would have prompted the committee to reject the application had they been brought to light earlier.

“You’re going to be stuck with that,” Moseley says. “If you had waited and followed your process and made sure it was complete, you would have known that information. We recommend making sure it’s complete; make sure you verified what you’re supposed to verify.”

**Rely on quality data**

As hospitals move forward with credentialing and privileging procedures, both Moseley and Steinberg believe there is going to be more of a focus on evaluating an individual’s quality data and how it compares to national averages or the goals of the hospital. Some of this focus may be fueled by the fact that national regulatory organizations like The Joint Commission and CMS are requiring hospitals to do more to track quality data as part of patient safety initiatives.

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The plus side of relying more on quality data is that it provides a more objective view of a physician’s performance, mitigating the possibility of politics or friendships invading the credentialing process.

Moseley believes the use of quality data is going to be increasingly critical in the recredentialing process in addition to the usual measurements such as peer recommendations, databank reports, and insurance claims history.

“The plaintiff’s question right off the bat is going to be, ‘Why did you recredential this guy when you knew he had a rate of return to OR twice every other surgeon?’ ” Moseley says.

In many states there is still a debate as to whether this information is protected by peer review, but Moseley says it’s best to assume a plaintiff attorney will get his or her hands on it if it’s publically available.

He also notes that just because a surgeon has unusually high rates in one area or another doesn’t mean he or she is not fit to practice, but the court is going to want to see that the credentialing committee took note of the high rates and documented why they were not considered to be a competency issue.

“We tell doctors all the time—and it’s the same thing for hospitals—if it’s not documented, it didn’t happen,” Moseley says.

Handling new equipment and procedures

In an age in which technology is constantly pushing forward, doctors are benefiting tremendously from new medical equipment that can bring simplicity to relatively complex procedures, and improve patient safety with minimally invasive techniques.

But new equipment adds a new dimension of privileging requirements, along with a number of associated legal pitfalls if the hospital doesn’t develop thorough policies and bylaws to ensure competency. Many hospitals are eager to offer cutting-edge procedures, but they need to balance that with ensuring physicians have the training to safely perform the procedures.

It’s important to remember that whether it’s a new type of procedure or the same procedure using a new type of equipment, it still requires separate privileges, says Samuel Steinberg, PhD, FACHE, a consultant with S.H. Steinberg Consulting, LLC, in Daytona Beach, Fla. There should be a review of the procedure and the physician’s competence to perform the procedure, as well as a review of the equipment and any additional staff training required to assist the physician.

Hospitals get into trouble legally when they privilege a physician to perform a new procedure by rationalizing that it’s just a variation of an existing procedure he or she is already privileged for. “My advice to them—and the courts have generally agreed—is that it’s not,” Steinberg says.

If a hospital already offers a service for robot-assisted bariatric surgery, for example, it is easier to privilege a physician who wants to perform that procedure because the policies and bylaws are already there. However, it’s much more intensive to create a new privilege altogether, says Jeff Moseley, partner at Buerger, Moseley, and Carson, PLC, in Franklin, Tenn. Before privileging anyone, the hospital should develop a policy based on nationally recognized standards for training and experience.

“Some have even gone so far as to say, ‘In order to get the initial service up we will bring in a consulting physician that has the experience and the appropriate number of cases to tell us what the standards should be,’ ” Moseley says. “That physician may even proctor the doctors for a few cases to make sure they are going about it the right way.”

Pay specific attention to how many cases the doctor needs to perform either in training or while being proctored. Steinberg says he recently testified in a case where a physician failed to be proctored for the first five cases of a new procedure.

“It’s a fairly involved process,” he says. “It needs to go through the credentialing process, it needs to have a new privilege assigned to it, and everyone needs to be trained and competent to perform the procedure.”
Telemedicine credentialing: One year after the CMS ruling

*Hospitals can credential through a proxy, but they still need to perform quality assessments and double-check their agreements*

One year ago, CMS handed down a ruling that allowed hospitals utilizing telemedicine providers to credential physicians through a proxy, using information about the physician from the distant-site facility rather than collecting and verifying information on their own.

The ruling put to rest a number of issues surrounding telemedicine, not the least of which was that CMS and The Joint Commission had previously differed greatly on the topic, with Joint Commission standards allowing credentialing through a proxy and CMS regulations requiring independent verification.

“If you were unfortunate enough to be surveyed by CMS and relying on The Joint Commission’s standards, you probably would have been in trouble because they weren’t sanctioned by CMS at that time,” says Greg Billings, executive director at the Robert J. Waters Center for Telehealth and eLaw in Washington, D.C.

Since then, there have been some general malpractice claims against telemedicine providers, particularly tele-radiologists, says Linda Siderius, an attorney at Caplan and Earnest, LLC, in Boulder, Colo.

“I see complaints filed against NightHawk radiologists for misreads,” she says. “Whether that’s computer issues or communication issues, I’ve seen those issues come up.”

Given the potential risks, it’s imperative that hospitals who are utilizing telemedicine services follow CMS *Conditions of Participation* and have the appropriate language in their agreements to avoid legal backlash.

**Maintaining responsibility**

It’s important to remember that the CMS regulation does not override an originating-site hospital’s decision to credential a telemedicine physician the same way it credentials physicians that are on staff. Hospitals can still go through the verification process, they just have the option to take the less onerous task and rely on information from the distant-site provider.

That said, most hospitals have chosen the less onerous route. However, choosing this option does not absolve the original-site hospital from having to make an appropriate, evidence-based credentialing decision.

“They can rely upon the privileging decision of the distant-site hospital to make recommendations to their governing body,” Billings says.

For example, rural hospitals typically use telemedicine services from larger hospitals that have more resources and a broader range of experienced physicians. A smaller rural hospital may be looking for telemedicine services from a pediatric cardiologist because it doesn’t have that expertise. The governing body of that small hospital still needs to make a decision on whether it wants to credential the telemedicine provider based on information provided by the larger hospital.

“I think you could probably argue that a small hospital is going out on a limb to rely on the decisions of the large hospital, but if they did it themselves they might find themselves in a situation where they are privileging someone that they don’t have the credentials to judge,” Billings says.

Hospitals contracting telemedicine services need to place particular emphasis on licensure expiration for telemedicine providers.

“Many times the telemedicine doctors are traveling all over the place and they don’t pay attention to license renewal requirements and credentialing requirements, and they let some of that stuff lapse,” Siderius says. “Some hospitals don’t have a good risk management system that triggers that.”

**Check your agreement**

Since most hospitals are relying on information from a distant site hospital or telemedicine organization, CMS stipulates that there needs to be a written agreement between the two parties that lays out mutual policies for
credentialing. The following items should be included in the agreement:

➤ If it’s a hospital, the distant site should be a Medicare-participating facility and the telemedicine practitioner at that distant-site facility should be privileged at that hospital. The distant-site hospital should also provide a current list of the practitioner’s privileges.

➤ The distant-site practitioner should hold a license that is either issued or recognized by the state in which the originating hospital is located. For example, telemedicine providers can practice in a different state and not have a license in that state, provided they meet the same licensure requirements set forth in the original site’s state. Siderius recommends trying to contract providers within the state so that both organizations are working under the same state regulations.

➤ If you are using a telemedicine entity (such as NightHawk), the agreement should stipulate that the entity can comply with CMS regulations for privileging and credentialing, even if it is not a Medicare-participating company. Billings notes that a number of telemedicine entities are Joint Commission accredited, which would mean they fall in line with CMS requirements as well.

As always, these written agreements should be reviewed by the hospital’s legal counsel, who is familiar with the nuances of telemedicine credentialing and privileging regulations, to ensure they contain the proper language. By now most distant-site providers are experienced enough—whether they are hospitals or telemedicine entities—with the entire process and should have a handle on including appropriate language.

“They are doing it for a number of doctors and a number of facilities,” Billings says. “And they have every reason to make the process work smoothly as well.”

**Continue doing peer review**

CMS regulations also do not absolve the original hospital of conducting periodic peer review of the telemedicine practitioner, and then providing that information to the distant site. This language should also be included in the agreement so the distant site can take action if a physician receives too many complaints or has quality issues.

“They have to have a process in place that provides information back to the distant site where the specialist is located, and that information must include all adverse events and complaints of telemedicine services provided into the originating-site hospital,” Billings says.

Siderius says smaller hospitals in particular should ensure they have the quality assessment resources to continually evaluate telemedicine providers.

“It depends on their quality programs, risk management programs, and professional review, and how robust all of those are,” she says. “In some small hospitals, they aren’t all that robust.”

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**Ohio district court rules to protect hospital documents against staffing company**

The United States District Court for the Northern District of Ohio granted a protective order requested by Cleveland Clinic Health Systems (Cleveland Clinic) to prevent the disclosure of certain documents in an indemnity lawsuit it filed against a nurse and staffing company. The court determined the documents were subject to Ohio’s peer review privilege.

On February 5, 2008, a patient was admitted to the emergency department of Huron Hospital (part of Cleveland Clinic) for alcohol intoxication. The patient was not fully connected to the emergency department’s monitoring system and was found dead the following morning.

Richard Briganti, employed by Innovative Placements, Inc. (IPI), was the nurse assigned to the patient. The patient’s estate sought compensation for his death and reached a settlement agreement with Cleveland Clinic.
Cleveland Clinic subsequently filed a complaint against IPI and Briganti for indemnity.

IPI later filed a letter with the court claiming Cleveland Clinic refused to respond to discovery requests. During an on-the-record meeting with the judge, Cleveland Clinic alleged some of the documents requested were protected by Ohio’s peer review privilege statute, as well as attorney-client privilege and the work product doctrine.

The court asked Cleveland Clinic to produce a privilege log with descriptive information about the documents and to file a motion for a protective order explaining the privilege for each document. Cleveland Clinic submitted a claim review report, a timeline with notes, a root cause analysis, and a quality review incident report.

The defendants argued that the privilege log was inadequate, the documents were not privileged under Ohio law (and even if they were protected, they should be discoverable under the fairness doctrine), and good cause existed to compel the documents to be discovered.

The plaintiffs offered testimony from Michele Reali-Sorrell, an assistant nurse manager at the time of the patient’s death. Reali-Sorrell testified that she was involved with the peer review committee convened to investigate the patient’s death.

This testimony, along with the privilege log, established the existence of a peer review committee, which is protected under Ohio law, according to the court. The court disagreed with the defendants’ argument that the documents should not be protected under the fairness doctrine. In addition, the court ruled that the documents were also protected under the attorney-client privilege and work product doctrine.

The defendants contended that good cause existed to produce the documents in order to refresh Briganti’s recollection of the circumstances of the event. However, the court noted that the circumstances surrounding the patient’s death were extraordinary and the defendants presented no evidence that Briganti’s memory had been exhausted. The court granted the plaintiff’s motion for protective order, and the documents were not disclosed to the defendants.


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Georgia Appeals Court reverses decision that peer review was motivated by malice

The Court of Appeals of Georgia reversed a lower court decision and ruled that a hospital was entitled to immunity under Georgia’s peer review protection law.

In September 2008, Dr. Adah E. Obekpa was appointed to the medical staff at DeKalb Medical Center (DMC) with clinical privileges in internal medicine. During the first few weeks of his appointment, DMC personnel indicated that Obekpa was not properly documenting the treatment of his patients. The chief of medicine spoke with Obekpa to address the issue.

Continued problems with documentation persisted, and DMC also began receiving complaints from staff members that Obekpa was not attentive or responsive to his patients and was not properly using DMC resources. Initially, the medical staff attempted an informal “collegial intervention” with Obekpa, and informed him that DMC would monitor him through progress notes and staff and patient complaints.

The following May, Obekpa was told that the medical staff would be initiating an investigation. He was informed of the peer review process and the bylaws, and was told that he could choose to resign and no report would be made to the NPDB. In July, the medical executive committee (MEC) began its investigation by appointing a committee of nine physicians to review 25 of Obekpa’s patient charts. The MEC informed Obekpa that the investigation would focus on documentation of patient treatment, responsiveness to patients and their families and DMC staff, and use of DMC resources.

Of the 25 cases, nine were found to have significant
problems by the credentials committee. The credentials committee met with Obekpa to discuss its findings, and then voted to limit the number of patients Obekpa saw for six months and have him attend training for medical record documentation, treatment plans, and appropriate use of DMC facilities. These recommendations were sent to the MEC, which made a final decision in September to adopt the credentials committee’s recommendations.

Obekpa requested a hearing panel in September to appeal the MEC’s decision. A panel conducted a three-day hearing, during which Obekpa admitted that he had failed to respond to 10 more peer review referrals about his performance. The panel issued a report unanimously adopting the MEC’s conclusions, but recommended “less severe corrective action” to avoid negatively affecting Obekpa’s career. Obekpa appealed the panel’s decision to DMC’s board of directors. Obekpa later told the board that he would withdraw his appeal if the board adopted the panel’s final recommendations. The MEC deferred the final decision to the board, which notified Obekpa that it had decided to adopt the original MEC recommendations, as well as reject Obekpa’s application for reappointment to the DMC staff in May.

Obekpa appealed the denial of his reappointment application and asked the board to adopt the panel’s recommendations. Obekpa’s legal counsel indicated that the peer review process was fair, but questioned why the board would ignore the panel’s recommendation. The board affirmed its initial decision to deny Obekpa’s reappointment.

Obekpa filed a lawsuit against DMC seeking to have the recommendations of the panel as the final action. A superior court denied DMC’s motion for summary judgment because one of the physicians on the peer review committee sought to limit patient referrals for Obekpa, which could infer malice. However, the appellate court reversed that decision, finding no evidence of malice and noting there were no concerns with any of the physicians conducting the investigation, and Obekpa himself conceded that any unfairness during the peer review process was fixed and the panel ultimately arrived at the correct decision.

The appellate court concluded that the superior court erred in its judgment that the peer review process was motivated by malice and reversed the lower court’s decision. DMC could report Obekpa to the NPDB following its decision to deny Obekpa’s reappointment.

Source: DeKalb Medical Center, Inc. v. Obekpa, 2012 WL 1521967 (Ga. App.).