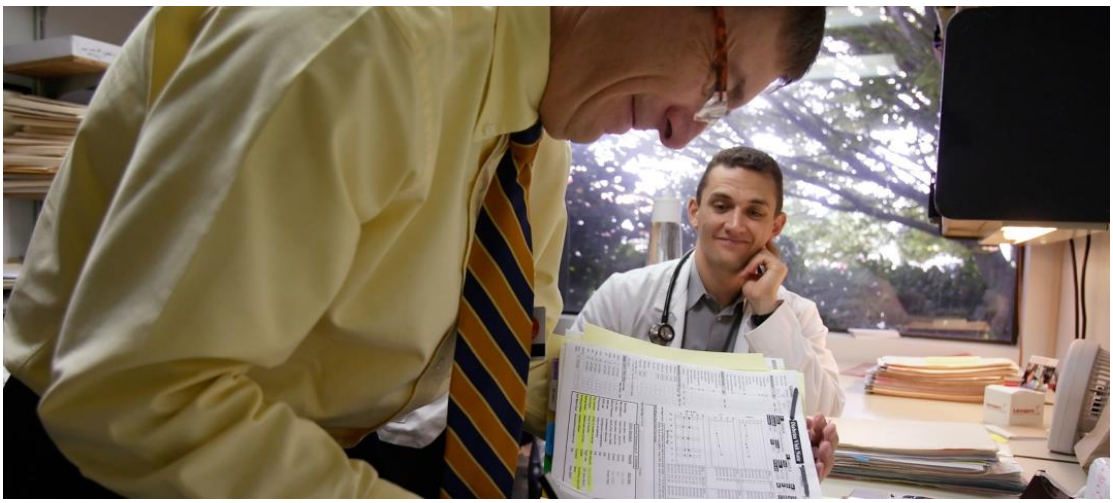
Lake Health District

Critical Access Hospital Case Review Manual



Disclaimer

This manual has been prepared as a service for the CAH Case Review Program Service to ensure the adequacy and consistency of the reviews in accordance with CAHCR policy. It is not intended to grant rights or impose obligations. This manual may contain references to statutes, regulations or other policy, but it is not intended to take the place of written laws or regulations. CAHCRP is not a case review body. The guidance contained herein is not intended to supersede the physician reviewer's professional judgment as to what approach to take or what specific procedures need to be performed. All activities are confidential.

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Contact Information

Lake Health District

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Overview of the CAH Case Review Program

Lake Health District's (hereafter referred as "LHD") Critical Access Hospital Case Review Program (CAHCRP) is an external case review service offered to a network of participating member hospitals on a fee-for-service schedule.

Through this network, LHD offers a true peer-to-peer, objective, and rural-appropriate medical opinion. We provide a safe and confidential environment for physicians to share opinions, personal learning, current information, and education. The LHD believes creating a safe peer-to-peer learning network, with physicians supporting physicians, is key to improving the safety and quality of patient care delivery.

The LHD coordinates and provides oversight of the CAH case review process which involves confidential and balanced rotation among participating network providers. Confidentiality is protected and maintained. However, to encourage peer-to-peer learning, we also provide an option for dialogue between peers, if both parties agree. If a second opinion review is requested, the medical record may be sent to an out-of-state provider contracted from a Peer Review Network or Quality Improvement Organization.

Need for External Case Review

The purpose of external case review is to provide healthcare organizations and physicians with objective and meaningful medical opinions. Some CAHs face significant challenges associated with obtaining unbiased, economical, and timely case review. Additionally there is no safe external environment for rural physicians to openly discuss and review medical cases. The LHD CAH Case Review program provides this environment. CAH Case Review is an effective, economical option for rural hospitals to improve patient care.

Current Medicare Conditions of Participation (COP), as defined in 42 CFR 485.641, require the CAH to make an agreement with a network hospital for peer review services. (See page 21 for 42 CFR 485.641.) Medicare COP require a representative sample ***of at least ten percent of both active and closed medical records*** to review the quality and appropriateness of the diagnosis and treatment furnished by doctors of medicine or osteopathy at the CAH. (See page 33 for Oregon CAH External Peer Review Requirements.)

The CAH Case Review Program is not intended to replace the hospital's internal peer review processes. External case review is helpful at times when any of the following conditions exist:

- Possible litigation
- Ambiguity in existing care analyses
- Lack of internal expertise to review care in a particular specialty
- The introduction of new technology for which the organization has no prior experience
- Conflict of interest compromises the appearance of objectivity
- Fair hearing expertise is needed or anticipated
- There is a general or specific concern about clinical outcomes

Role of the LHD Critical Access Hospital Case Review Program

The CAH Case Review Program networks through group of hospitals signed up for the program to provide mutual peer-to-peer review. LHD is responsible for setting policy and establishing procedures for case review. LHD provides services to network hospitals and physician case review bodies and its quality assurance activities are confidential and protected by law. LHD may share guidelines, best practices and resources with the network members.

Role of the Network Hospital

The participating network hospital (hereinafter referred to as "Hospital") provides a point of contact and qualified medical staff to perform mutual case review. The Hospital is responsible to ensure medical staff meets CAHCRP requirements to participate in the case review process. (See page 9 for Physician Reviewer Requirements.)

The Hospital uses internal criteria and procedures to identify the need for case review. The Hospital requesting case review is responsible for any follow up necessitated by case review findings. The Hospital, as the case review body, is ultimately responsible for implementing disciplinary action, education or quality improvement to ensure the desired outcome is achieved.

Purpose of the CAH Case Review Manual

The purpose of this manual is to provide the network Hospitals and physician reviewers with necessary information to complete case review.

CAH Case Review Policy & Procedures

Policy

CAHCRP establishes a confidential and protected external case review network among CAH Hospitals. (See page 23 for 42 CFR 485.603.) CAHCRP provides coordination and oversight of the case review process. All activities are intended to be privileged and confidential in accordance with ORS 41.675. (See page 24 for ORS 41.675.)

Requirements

1. The Hospital signs the CAHCRP Agreement to comply with HIPAA regulations. (See page 35 for CAHCR External Case Review Agreement.)

2. Medical and Administrative staff within each participating CAH Hospital will review and sign the CAHCRP Confidentiality Agreement and agree to adhere to the policy as written. (See page 38 for CACHR Confidentiality Agreement.)

3. The Hospital maintains a list of reviewing physicians and ensures they meet CAHCRP physician requirements for participation in the external case review process. (See page 11 for Physician Reviewer Requirements.)

4. The Hospital designates a single contact person to receive, handle, track, follow-up, and return medical records that have been submitted for review.

5. The Hospital requesting a review is responsible for providing the results and for following up with the physician(s) whose case was reviewed.

Procedures for CAHCRP

Hospital <u>Sending</u> Medical Records:

1. Send an e-mail requesting case review to Peerreview@LakeHealthDistrict.org.

2. For each case note;
   - for cause or random review
   - specialty to be reviewed by

3. A case number will be assigned to each chart and an e-mail issued with an itemized invoice. (If you have an internal tracking number, include that and it will be noted in all tracking). At this time or when the check has been received the case can be uploaded into the web portal.

4. Send the check to the following address using second day service:

   Lake District Hospital
   Attn: Mikell Newton
   700 South J Street
   Lakeview OR 97630

5. Once payment has been received the case will be referred to the reviewing facility. Timelines for processing are 45 days for random reviews, and two weeks if they are for cause. An email will be generated when your case is referred and when the review has been completed in the portal.

Hospital <u>Receiving</u> Medical Records:

6. The case is assigned to a site based on the availability of a reviewer in that specialty and the facility will receive a notification via email. The reviewing site issues it to the appropriate reviewer within the facility.

7. The reviewer will have 45 days to complete a random review and two weeks to complete a for cause review.

8. The report is available within the case for completion.

NOTE: Review must be completed and documents returned to LHD within 30 days of receipt.

The External Case Review

Physician Reviewer Requirements

The COP requires that the reviewing physician be either a doctor of medicine or osteopathy. (See page 21 for 42 CFR 485.641.) It is the intent of the LHD to find reviewers of like specialties for each medical case reviewed.

LHD may elect to use any qualified physician to review the case, if the use of the required reviewer is impractical, would create unavoidable potential conflict of interest, or would compromise the effectiveness or efficiency of the review process. However, case reviews of doctors of dentistry, optometry, or podiatry are limited to peers with the same licensure.

Active Practice Requirements

Physician reviewers must actively practice medicine, at a minimum average of 20 hours per week, during the year.

Physician reviewers must have active Hospital staff privileges. The Hospital will verify annually that this requirement is met.

Licensure Requirements

A physician reviewer must have a current unrestricted license to practice medicine.

Specialty Requirements

Specialty physician reviews are performed by a specialist in the same field. Specialists are defined as physicians who are certified by a specialty board recognized by the American Board of Medical Specialties (for MDs) or by a specialty board under the auspices of the American Osteopathic Association (for DOs). The Hospital verifies certification of specialty physician reviewer.

Setting Requirements

The physician reviewer must practice in a rural setting.

Statutory Obligations

It is the obligation of any health care practitioner or other person who furnishes or orders health care items or services reimbursed under Medicare to ensure that, to the extent of his or her authority, those services are:

1. Furnished economically and only when and to the extent medically necessary.

2. Of a quality that meets all professionally recognized standards of health care.

3. Supported by evidence of the medical necessity and quality of the services in the medical record documentation.

These obligations apply in all cases, regardless of whether payment is made directly to the provider (e.g., assignment) or to the beneficiary, or if payment is not made.

Legal Responsibility & Liability

To avoid liability, physician reviewers must not assume responsibility for medical care of any patient whose care they are reviewing. Throughout the review process, the physician reviewer must:

1. Maintain complete confidentiality of the patient, provider and practitioner.

2. Avoid direct involvement with the review if there is a known conflict of interest, such as:
   - Prior involvement with the same patient
   - A close working relationship with the attending physician
   - Potential financial gain from the outcome of the review (e.g., direct professional competition with the physician involved)
   - Or other bias

3. Make determinations based on acceptable standards of practice within the Oregon community rather than on personal preference of treatment.

4. Follow established case review procedures as determined by CAHCRP.

Confidentiality and HIPAA Compliance

The CAH Case Review Coordinator will verify that Confidentiality Agreement is on file for each reviewing physician. (See page 38 for CAHCRP Confidentiality Agreement.)

Oregon Revised Statues and Peer Review Protections

The CAHCRP is an agent to and assisting a “peer review body” and its physician reviewers are “peer review persons” as described in ORS 41.675(4). (See page 24 for ORS 41.675.) The “data” of such organizations are privileged by ORS 41.675. Data includes all oral communications or written reports. Data and communications concerning findings on reviews are only to be sent to the LHD CAHCRP and authorized persons, firms and organizations. This is imperative because voluntary disclosure to any third party could result in a waiver of this privilege and potential liability.

Role of the Physician External Case Reviewer

The physician reviewer provides objective medical opinion and applicable educational resources. The physician reviewer completes a review based on his/her medical judgment, expertise, and knowledge of local practice standards.

It is *imperative* that the review is completed within the 30 days of receipt.

It is equally important that a physician reviewer be able to remain objective in his/her review process and also adhere to CAHCRP procedures, federal and state regulations and requirements.

Approach to Medical Record Review

Review the medical record with the information and documentation available to the parties involved at the time the decision was made.

Remember the following:

1. There is more than one way to manage a patient's medical condition. Even if you would not treat a patient using this approach, if the care meets acceptable standards and is appropriate for the patient's condition, then it is considered acceptable.

2. You will be provided with the entire medical record for review. Please remember, you may have more information available than the physician or consultant did at the time of medical decision-making or treatment.

3. Do not try to read between the lines in the review. Make your review evaluation on the documentation available in the medical record. However, if you feel there is missing information or need additional documentation, your Hospital contact will obtain additional information for you to complete the review.

4. If you identify a potential quality of care concern, do not be reluctant to document it. The sending physician(s) and Hospital needs your objective opinion to determine opportunities for improvement. You will not be making any final decisions. Your review is valuable and provides education and insight for the External Case Review body at the sending Hospital.

5. Remember that the purpose of the case review is mutual peer-to-peer learning and to share best practice information and identify areas for process improvement.

6. Immediately notify your Hospital contact and return the review if you believe that there may be a potential conflict of interest or other biases related to a particular review.

7. Maintain confidentiality throughout the review.

8. If you have any questions regarding a review, contact your Hospital contact. S/he will help you through the process.

How to Review a Medical Record

A standard and objective approach to medical record review is necessary to provide peers with meaningful information for effective quality assurance and improvement activities. These instructions provide a systematic approach to medical record review to ensure consistency among case reviewers. (See page 34 for Review Guidelines for Medical Record Documentation.)

1. Note the medical record number, date of admission, date of discharge, age of patient, and level of care given.

2. Note how the patient arrived at the hospital and the documented condition of the patient on arrival.

3. Review the physician's admission note for the patient's presenting symptoms and physical findings. Identify the working diagnosis.

4. Review the nurse's notes and observations at the time of admission. Do they agree with the physician's findings?

5. Read the physician's admission orders. Are the orders appropriate for the symptoms and findings listed in the physician's admission note?

6. Review the daily records, including physicians' orders, physicians' progress notes, laboratory and x-ray data, nurses' documentation, and consultants' records.

7. Evaluate the patient's daily progress. Consider the following questions:

    - Are diagnostic studies ordered appropriately? Are abnormal findings identified by the physicians?

    - Do the physicians' progress notes and orders reflect evaluation of these findings?

    - Do the physicians' progress notes and the nurses' documentation reflect essentially the same patient condition? If not, do the physicians' progress notes explain the differences and provide adequate clarification?

    - Are the diagnoses confirmed by documented symptoms, physical findings, and diagnostic studies?

    - Is there sufficient documentation to ensure that treatment is correct and that responses to treatment and medications are as expected?

    - Has the patient shown any adverse responses to treatment or medications? If so, has therapy been changed appropriately?

    - Have the physicians' orders been carried out correctly and in a timely manner? Is this properly documented in the ancillary disciplines or nurses’ notes?

- Has the patient shown daily improvement? If not, have the physicians responded appropriately (e.g., changes in orders, ordering of new studies, change of medication and dose level, use of consultants)?

- Are changes in the patient's condition the result of a hospital-acquired injury or infection (e.g., medication errors, falls)?

- Is discharge planning documented? Has post discharge care been appropriately arranged and documented?

- Is the patient's condition stable at the time of discharge? Have the physicians documented the patient's progress through the time of discharge, and the condition of the patient at the time of discharge? Is there adequate explanation of any abnormal lab and x-ray studies present at the time of discharge? Are there follow-up instructions for the patient after discharge?

- Is the record complete? Was the record completed in a timely fashion?

- Finally, are the diagnoses listed properly and sequenced correctly (e.g., principal diagnosis with secondary diagnoses)?

The case review data gathered in a systematic approach provides meaningful information for effective quality assurance activities

Medical Review Criteria

Inpatient Admission Review

The purpose of admission review is to determine if the patient met the requirement of medical necessity and appropriateness to be treated in an inpatient setting. When interpreting medical necessity, the physician reviewer must use the federal definition. (See page 42 for link to CMS Medicare Benefit Policy Manual.)

Specific Instructions

To make a determination that inpatient services were medically necessary, there must be a finding that services are:

1. Medically required by the patient's medical condition.

2. Of the type that based on the patient's medical condition, could only be provided safely and effectively within the inpatient setting.

3. Could not have been provided safely and effectively in an alternate setting, i.e., observation status, outpatient or day surgery, Intermediate Care Facility (ICF), Skilled Nursing Facility (SNF) or Home Health Agency (HHA).

To determine if an admission was medically necessary and appropriate, the physician reviewer should base their decisions on:

1. The history of the patient prior to admission

2. The treatment the patient received in the outpatient setting

3. The clinical presentation of the patient at the time of admission

4. Expectation that the patient’s condition would require at least a 24-hour stay

Determination of medical necessity should not be based on:

1. The actual recovery time of the patient

2. The actual length of stay required

3. The failure of the physician to provide the intensity of service, which retrospectively appears to have been required

Inpatient admissions are considered inappropriate, if the admission is for:

1. Custodial care

2. Social reasons

3. Outpatient-type testing performed for chronic problems with no acute component

4. The convenience of the patient and/or the physician

The appropriateness of the admission determination must be based on the medical evidence available to the admitting physician at the time of admission. The decision should not be based on information (e.g., test results) that became available after admission (except when post-admission findings support admission necessity). Your determination of medical necessity and appropriateness should not be based on whether or not the patient recovered rapidly.

Explain your decision thoroughly and support it with medical rationale. Base your decision on information available at the time of the patient's admission, rather than on retrospective findings.

Daily Progress Review

The purpose of the daily progress review is to determine if patient care was appropriate and responsive to patient's condition.

Specific Instructions

To make a determination that patient's progress was reviewed daily, there must be documentation to reflect:

1. Diagnostic studies are ordered appropriately and abnormal findings are identified by the physicians.

2. Physicians' progress notes and orders reflect evaluation of these studies.

3. Physicians' progress notes are consistent with documentation of other disciplines and reflect the same patient condition. If not, the physicians' progress notes explain or provide adequate clarification.

4. Diagnoses are confirmed by documented symptoms, physical findings, and diagnostic studies.

5. Sufficient documentation is present to ensure treatment is correct and responses to treatment and medications are as expected.

6. Therapy has been changed appropriately to address any adverse response to treatment or medications.

7. Physicians' orders have been carried out correctly and in a timely manner and properly documented.

8. The patient has shown daily improvement and, if not, the physicians have responded appropriately (e.g., changes in orders, ordering of new studies, change of medication and dose level, use of consultants).

9. Discharge planning is documented.

Note: Address in your review any changes in the patient's condition, which may be the result of a hospital-acquired injury or infection (e.g., medications, errors, and falls).

Discharge Review

The purpose of this review is to determine if the patient was medically stable at the time of discharge and that discharge planning was appropriate and complete. If the patient is unstable or if discharge planning is incomplete at the time of discharge, this is considered a premature discharge. A premature discharge could reflect a quality of care concern unless it is clearly documented that the patient requested discharge or left AMA. (See page 17 for Readmission Review).

Specific Instructions

To make a determination that the discharge is appropriate, there must be documentation to reflect:

1. The patient was medical stability at the time of discharge.

2. The reasonableness of the physician's expectation that the patient could continue to be managed in an alternative level of care setting.

3. The setting and level of care was appropriate for the patient's condition at discharge (e.g., outpatient or alternate settings).

4. To determine that if the patient requested premature discharge; the risk was adequately explained to the patient.

5. If the patient was chronically unstable and the physician and/or patient believed that it was reasonable to expect that further management could be safely achieved in an outpatient or alternative care setting.

Note: Do not base your premature discharge determination on retrospective knowledge that the patient required readmission.

Readmission Review

The purpose of readmission review is to determine if the patient was medically stable at the time of discharge from the hospital and/or whether the readmission was due to the need for continued care that should have been provided at the time of the first admission.

Specific Instructions

To make a determination that the readmission is not a result of premature discharge, there must be documentation that:

1. The readmission is not as result of incomplete discharge planning.

2. Patient's condition was stable at time of discharge from the first admission.

3. The patient's need for further testing and treatment was adequately addressed.

Note: Readmission as a result of a premature discharge could reflect a quality of care concern unless it is clearly documented that the patient condition unexpectedly changed, or the patient requested premature discharge or left AMA.

Transfer Review

The purpose of transfer review is to ensure that care was coordinated throughout the transfer and EMTALA obligations were met. (See page 25 for EMTALA regulations.) The patient was appropriately stabilized to the ability of the transferring hospital. The transfer was medically necessary or requested by the patient.

Specific Instructions

In a transfer review, the physician reviewer must evaluate the following:

1. The transfer was medically necessary and the patient required services that could not have been provided in the existing facility.

2. The presence of documented transfer forms or request from the patient for a transfer to another facility. (See page 40 for an example of the EMTALA Transfer Form.) If there is documentation that the patient requested to be transferred to a different hospital, this is considered acceptable.

3. At the time the patient was being admitted to the receiving hospital, did the patient's condition require acute hospitalization? If the patient was not at an acute level of care at the second hospital, that admission could be denied.

Note: The medical instability of the patient at the time of transfer; an emergent or urgent transfer, due to a life-threatening situation, could negate this requirement.

Procedure Review

The purpose of a procedure review is to determine the medical necessity for the procedure and the appropriateness of the setting in which the procedure is performed.

Specific Instructions

Using the documentation provided in the medical record, determine if:

1. The procedure performed on the patient was medically necessary with respect to the acceptable standards of practice within the community.

2. The procedure could have been appropriately performed in the outpatient setting, please document your rationale for this determination.

3. The procedure needed to be performed in the inpatient setting, you need to justify that decision with medical rationale.

4. If you agree that this procedure could have been safely performed in the outpatient setting, please support that with a medical decision as well.

Note: A medically unnecessary procedure is usually considered to be a quality concern, and this should also be addressed.

Ambulatory Surgery Review

The purpose of ambulatory surgery review is to determine the medical necessity for the procedure performed the appropriateness of the setting for the procedure performed and that the quality of the care provided was acceptable for the situation, as determined by accepted standards of practice.

Specific Instructions

Using the documentation provided in the medical record, determine if:

1. The procedure performed on the patient was medically necessary with respect to the acceptable standards of practice within the community.

2. The procedure could have been appropriately performed in the outpatient setting, please document your rationale for this determination.

3. The procedure needed to be performed in the inpatient setting; you need to justify that decision with medical rationale.

4. If you agree that this procedure could have been safely performed in the outpatient setting, please support that with a medical decision as well.

Note: The physician reviewer should conduct this review based on the information available in the medical record and what is expected to be the community standard. Each record should contain sufficient documentation to determine medical necessity.

Quality Review

The purpose of quality review is to identify whether the care provided meets the acceptable standards of practice within the community. The community in this context is to be defined as the State of Oregon.

Although there may be some differences in services available within areas, ORHQN's philosophy is that the cognitive skills and abilities of physicians within different areas should not vary.

The Objectives of a Quality Review

1. To identify *quality concerns* about care rendered to patients as well as to identify practice patterns associated with positive or adverse outcomes.

2. To identify any *systems of practice* that may negatively impact care.

3. To determine *the source(s)* or individuals, providers, etc. that is/are responsible for the quality concerns.

4. To determine if a *significant departure from the expected standard* of practice has occurred.

5. To provide *peer advice,* including citations from the medical literature as applicable, to help improve future care.

   (*Modified from Health Care Excel's Handbook for Physician Reviewers)*

Problem Identification

Physician review decisions are based on the "standard of practice in the community". Physician reviewers are instructed to determine if the management in the review represents an "acceptable alternative" rather than their personal preference.

Completing the Case Review Report

1. Completely fill out the Case Review Report Form or dictate per customary hospital process using the Case Review Report Form as a template and reference the assigned CAHCRP case number. (See page 39 for Case Review Report.)

2. Attach completed report or forward dictation to the medical record and return to the Hospital contact person.

3. Use only the attached CAH Case Review Report Form.

4. Attach journal articles or additional information.

Regulations & Miscellaneous Information

Code of Federal Regulations

[Code of Federal Regulations]
[Title 42, Volume 3]
[Revised as of October 1, 2005]
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[Page 611-612]

TITLE 42--PUBLIC HEALTH

CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES (CONTINUED)

PART 485_CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS--Table of Contents

Subpart F_Conditions of Participation: Critical Access Hospitals (CAHs)

Sec. 485.**641** Condition of participation: Periodic evaluation and quality assurance review.

(a) Standard: Periodic evaluation—
(1) The CAH carries out or arranges for a periodic evaluation of its total program. The evaluation is done at least once a year and includes review of--
(i) The utilization of CAH services, including at least the number of patients served and the volume of services;
(ii) A representative sample of both active and closed clinical records; and
(iii) The CAH's health care policies.
(2) The purpose of the evaluation is to determine whether the utilization of services was appropriate, the established policies were followed, and any changes are needed.
(b) Standard: Quality assurance. The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that--
(1) All patient care services and other services affecting patient health and safety, are evaluated;
(2) Nosocomial infections and medication therapy are evaluated;
(3) The quality and appropriateness of the diagnosis and treatment furnished by nurse practitioners, clinical nurse specialists, and physician assistants at the CAH are evaluated by a member of the CAH staff who is a doctor of medicine or osteopathy or by another doctor of medicine or osteopathy under contract with the CAH;

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(4) The quality and appropriateness of the diagnosis and treatment furnished by doctors of medicine or osteopathy at the CAH are evaluated by--
(i) One hospital that is a member of the network, when applicable;

(ii) One QIO or equivalent entity; or

(iii) One other appropriate and qualified entity identified in the State rural health care plan; and

(5)(i) The CAH staff considers the findings of the evaluations, including any findings or recommendations of the QIO, and takes corrective action if necessary.

(ii) The CAH also takes appropriate remedial action to address deficiencies found through the quality assurance program.

(iii) The CAH documents the outcome of all remedial action.

[58 FR 30671, May 26, 1993, as amended at 62 FR 46037, Aug. 29, 1997; 63 FR 26359, May 12, 1998

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TITLE 42--PUBLIC HEALTH

CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES (CONTINUED)

PART 485_CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS--Table of Contents

Subpart F_Conditions of Participation: Critical Access Hospitals (CAHs)

Sec. 485.603 Rural health network.

A rural health network is an organization that meets the following specifications:
(a) It includes--
(1) At least one hospital that the State has designated or plans to designate as a CAH; and
(2) At least one hospital that furnishes acute care services.
(b) The members of the organization have entered into agreements regarding--
(1) Patient referral and transfer;
(2) The development and use of communications systems, including, where feasible, telemetry systems and systems for electronic sharing of patient data; and
(3) The provision of emergency and nonemergency transportation among members.
(c) Each CAH has an agreement with respect to credentialing and quality assurance with at least--
(1) One hospital that is a member of the network when applicable;
(2) One QIO or equivalent entity; or
(3) One other appropriate and qualified entity identified in the State rural health care plan.

[58 FR 30671, May 26, 1993, as amended at 62 FR 46035, Aug. 29, 1997; 63 FR 26359, May 12, 1998]

ORS 41.675

41.675 Inadmissibility of certain data provided to peer review body of health care providers and health care groups. (1) As used in this section, "peer review body" includes tissue committees, governing bodies or committees including medical staff committees of a health care facility licensed under ORS chapter 441, medical staff committees of the Department of Corrections and similar committees of professional societies, a health care service contractor as defined in ORS 750.005, an emergency medical service provider as defined in ORS 41.685 or any other medical group or provider of medical services in connection with bona fide medical research, quality assurance, utilization review, credentialing, education, training, supervision or discipline of physicians or other health care providers or in connection with the grant, denial, restriction or termination of clinical privileges at a health care facility. "Peer review body" also includes utilization review and peer review organizations.

(2) As used in subsection (3) of this section, "data" means all oral communications or written reports to a peer review body, and all notes or records created by or at the direction of a peer review body, including the communications, reports, notes or records created in the course of an investigation undertaken at the direction of a peer review body.

(3) All data shall be privileged and shall not be admissible in evidence in any judicial, administrative, arbitration or mediation proceeding. This section shall not affect the admissibility in evidence of records dealing with a patient's care and treatment, other than data or information obtained through service on, or as an agent for, a peer review body.

(4) A person serving on or communicating information to any peer review body or person conducting an investigation described in subsection (1) of this section shall not be examined as to any communication to or from, or the findings of, that peer review body or person.

(5) A person serving on or communicating information to any peer review body or person conducting an investigation described in subsection (1) of this section shall not be subject to an action for civil damages for affirmative actions taken or statements made in good faith.

(6) Subsection (3) of this section shall not apply to proceedings in which a health care practitioner contests the denial, restriction or termination of clinical privileges by a health care facility or the denial, restriction or termination of membership in a professional society or any other health care group. However, any data disclosed in those proceedings shall not be admissible in any other judicial, administrative, arbitration or mediation proceeding. [1963 c.181 §1; 1971 c.412 §1; 1975 c.796 §11; 1977 c.448 §9; 1981 c.806 §1; 1991 c.225 §1; 1995 c.485 §1; 1997 c.791 §6; 1997 c.792 §§29,29a]

ORS 677.095

The Oregon statutes provide a standard of care required by statute of physicians:
A physician or podiatric physician and surgeon licensed to practice medicine or podiatry by the Board of Medical Examiners for the State of Oregon has the duty to use that degree of care, skill and diligence that is used by ordinarily careful physicians or podiatric physicians and surgeons in the same or similar circumstances in the community of the physician or podiatric physician and surgeon or a similar community. ORS 677.095(1)

EMTALA

[Code of Federal Regulations]
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[Page 941-947]

TITLE 42--PUBLIC HEALTH

CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES (CONTINUED)

PART 489_PROVIDER AGREEMENTS AND SUPPLIER APPROVAL--Table of Contents

Subpart B_Essentials of Provider Agreements

Sec. 489.24 Special responsibilities of Medicare hospitals in emergency cases.

(a) Applicability of provisions of this section. (1) In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay)
``comes to the emergency department'', as defined in paragraph (b) of this section, the hospital must—

(i) Provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of Sec. 482.55 of this chapter concerning emergency services personnel and direction; and

(ii) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section.

(2) Nonapplicability of provisions of this section. Sanctions under this section for inappropriate transfer during a national emergency do not apply to a hospital with a dedicated emergency department located in an emergency area, as specified in section 1135(g)(1) of the Act.

(b) Definitions. As used in this subpart--

Capacity means the ability of the hospital to accommodate the individual requesting examination or treatment of the transferred individual. Capacity encompasses such things as numbers and availability of qualified staff, beds and equipment and the hospital's past practices of accommodating additional patients in excess of its occupancy limits.

Comes to the emergency department means, with respect to an individual who is not a patient (as defined in this section), the individual--

(1) Has presented at a hospital's dedicated emergency department, as defined in this section, and requests examination or treatment for a medical condition, or has such a request made on his or her behalf. In the absence of such a request by or on behalf of the individual, a request on behalf of the

individual will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for a medical condition;

(2) Has presented on hospital property, as defined in this section, other than the dedicated emergency department, and requests examination or treatment for what may be an emergency medical condition, or has such a request made on his or her behalf. In the absence of such a request by or on behalf of the individual, a request on behalf of the individual will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs emergency examination or treatment;

(3) Is in a ground or air ambulance owned and operated by the hospital for purposes of examination and treatment for a medical condition at a hospital's dedicated emergency department, even if the ambulance is not on hospital grounds. However, an individual in an ambulance owned and operated by the hospital is not considered to have ``come to the hospital's emergency department'' if--

(i) The ambulance is operated under communitywide emergency medical service (EMS) protocols that direct it to transport the individual to a hospital other than the hospital that owns

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The ambulance; for example, to the closest appropriate facility. In this case, the individual is considered to have come to the emergency department of the hospital to which the individual is transported, at the time the individual is brought onto hospital property;

(ii) The ambulance is operated at the direction of a physician who is not employed or otherwise affiliated with the hospital that owns the ambulance; or

(4) Is in a ground or air nonhospital-owned ambulance on hospital property for presentation for examination and treatment for a medical condition at a hospital's dedicated emergency department. However, an individual in a nonhospital-owned ambulance off hospital property is not considered to have come to the hospital's emergency department, even if a member of the ambulance staff contacts the hospital by telephone or telemetry communications and informs the hospital that they want to transport the individual to the hospital for examination and treatment. The hospital may direct the ambulance to another facility if it is in ``diversionary status,'' that is, it does not have the staff or facilities to accept any additional emergency patients. If, however, the ambulance staff disregards the hospital's diversion instructions and transports the individual onto hospital property, the individual is considered to have come to the emergency department.

Dedicated emergency department means any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:

(1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;

(2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or

(3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

Emergency medical condition means--

(1) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in--

(i) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(ii) Serious impairment to bodily functions; or

(iii) Serious dysfunction of any bodily organ or part; or

(2) With respect to a pregnant woman who is having contractions--

(i) That there is inadequate time to effect a safe transfer to another hospital before delivery; or

(ii) That transfer may pose a threat to the health or safety of the woman or the unborn child.

Hospital includes a critical access hospital as defined in section 1861(mm)(1) of the Act.

Hospital property means the entire main hospital campus as defined in Sec. 413.65(b) of this chapter, including the parking lot, sidewalk, and driveway, but excluding other areas or structures of the hospital's main building that are not part of the hospital, such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare, or restaurants, shops, or other nonmedical facilities.

Hospital with an emergency department means a hospital with a dedicated emergency department as defined in this paragraph (b).

Inpatient means an individual who is admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services as described in Sec. 409.10(a) of this chapter with the expectation that he or she will remain at least overnight and occupy a bed even though the situation later develops that the individual can be discharged

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or transferred to another hospital and does not actually use a hospital bed overnight.

Labor means the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman experiencing contractions is in true labor unless a physician certifies that, after a reasonable time of observation, the woman is in false labor.

Participating hospital means (1) a hospital or (2) a critical access hospital as defined in section 1861(mm)(1) of the Act that has entered into a Medicare provider agreement under section 1866 of the Act.

Patient means--

(1) An individual who has begun to receive outpatient services as part of an encounter, as defined in Sec. 410.2 of this chapter, other than an encounter that the hospital is obligated by this section to provide;

(2) An individual who has been admitted as an inpatient, as defined in this section.

Stabilized means, with respect to an ``emergency medical condition'' as defined in this section under paragraph (1) of that definition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility or, with respect to an ``emergency medical condition'' as defined in this section under paragraph (2) of that definition, that the woman has delivered the child and the placenta.

To stabilize means, with respect to an ``emergency medical condition'' as defined in this section under paragraph (1) of that definition, to provide such medical treatment of the condition necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility or that, with respect to

an ``emergency medical condition'' as defined in this section under paragraph (2) of that definition, the woman has delivered the child and the placenta.

Transfer means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (i) has been declared dead, or (ii) leaves the facility without the permission of any such person.

(c) Use of dedicated emergency department for nonemergency services. If an individual comes to a hospital's dedicated emergency department and a request is made on his or her behalf for examination or treatment
for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition.

(d) Necessary stabilizing treatment for emergency medical conditions.--(1) General. Subject to the provisions of paragraph (d)(2) of this section, if any individual (whether or not eligible for Medicare benefits) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either--

(i) Within the capabilities of the staff and facilities available at the hospital, for further medical examination and treatment as required to stabilize the medical condition.

(ii) For transfer of the individual to another medical facility in accordance with paragraph (e) of this section.

(2) Exception: Application to inpatients. (i) If a hospital has screened an individual under paragraph (a) of this section and found the individual to have an emergency medical condition, and admits that individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual.

(ii) This section is not applicable to an inpatient who was admitted for elective (nonemergency) diagnosis or treatment.

(iii) A hospital is required by the conditions of participation for hospitals

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under Part 482 of this chapter to provide care to its inpatients in accordance with those conditions of participation.

(3) Refusal to consent to treatment. A hospital meets the requirements of paragraph (d)(1)(i) of this section with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of the examination and treatment, but the individual (or a person acting on the individual's behalf) does not consent to the examination or treatment. The medical record must contain a description of the examination, treatment, or both if applicable, that was refused by or on behalf of the individual. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of the person acting on his or her behalf). The written document should indicate that the person has been informed of the risks and benefits of the examination or treatment, or both.

(4) Delay in examination or treatment.

(i) A participating hospital may not delay providing an appropriate medical screening examination required under paragraph (a) of this section or further medical examination and treatment required under paragraph (d)(1) of this section in order to inquire about the individual’s method of payment or insurance status.

(ii) A participating hospital may not seek, or direct an individual to seek, authorization from the individual's insurance company for screening or stabilization services to be furnished by a hospital, physician, or non-physician practitioner to an individual until after the hospital has provided the appropriate medical screening examination required under paragraph (a) of this section, and initiated any further medical examination and treatment that may be required to stabilize the emergency medical condition under paragraph (d)(1) of this section.

(iii) An emergency physician or non-physician practitioner is not precluded from contacting the individual's physician at any time to seek advice regarding the individual's medical history and needs that may be relevant to the medical treatment and screening of the patient, as long as this consultation does not inappropriately delay services required under paragraph (a) or paragraphs (d)(1) and (d)(2) of this section.

(iv) Hospitals may follow reasonable registration processes for individuals for whom examination or treatment is required by this section, including asking whether an individual is insured and, if so, what that insurance is, as long as that inquiry does not delay screening or treatment. Reasonable registration processes may not unduly discourage individuals from remaining for further evaluation.

(5) Refusal to consent to transfer. A hospital meets the requirements of paragraph (d)(1)(ii) of this section with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with paragraph (e) of this section and informs the individual (or a person acting on his or her behalf) of the risks and benefits to the individual of the transfer, but the individual (or a person acting on the individual's behalf) does not consent to the transfer. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of a person acting on his or her behalf). The written document must indicate the person has been informed of the risks and benefits of the transfer and state the reasons for the individual's refusal. The medical record must contain a description of the proposed transfer that was refused by or on behalf of the individual.

(e) Restricting transfer until the individual is stabilized--(1) General. If an individual at a hospital has an emergency medical condition that has not been stabilized (as defined in paragraph (b) of this section), the hospital may not transfer the individual unless-- (i) The transfer is an appropriate transfer (within the meaning of paragraph (e)(2) of this section); and

(ii)(A) The individual (or a legally responsible person acting on the individual's behalf) requests the transfer, after being informed of the hospital's obligations under this section and of the risk of transfer. The request must be in writing and indicate the reasons

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for the request as well as indicate that he or she is aware of the risks and benefits of the transfer;

(B) A physician (within the meaning of section 1861(r)(1) of the Act) has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based; or

(C) If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital in its by-laws or rules and regulations) has signed a certification described in paragraph (e)(1)(ii)(B) of this section after a physician (as defined in section
1861(r)(1) of the Act) in consultation with the qualified medical person, agrees with the certification and subsequently countersigns the certification. The certification must contain a summary of the risks and benefits upon which it is based.

(2) A transfer to another medical facility will be appropriate only in those cases in which--

(i) The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(ii) The receiving facility--

(A) Has available space and qualified personnel for the treatment of the individual; and

(B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(iii) The transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer, including available history, records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) required under paragraph (e)(1)(ii) of this section, and the name and address of any on-call physician (described in paragraph (g) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records (e.g., test results not yet available or historical records not readily available from the hospital's files) must be sent as soon as practicable after transfer; and

(iv) The transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.

(3) A participating hospital may not penalize or take adverse action against a physician or a qualified medical person described in paragraph (e)(1)(ii)(C) of this section because the physician or qualified medical person refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized, or against any hospital employee because the employee reports a violation of a requirement of this section.

(f) Recipient hospital responsibilities. A participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers) may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.

(g) Termination of provider agreement. If a hospital fails to meet the requirements of paragraph (a) through (f) of this section, CMS may terminate the provider agreement in accordance with Sec. 489.53.

(h) Consultation with Quality Improvement Organizations (QIOs)--(1) General. Except as provided in paragraph (h)(3) of this section, in cases where a medical opinion is necessary to determine

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a physician's or hospital's liability under section 1867(d)(1) of the Act, CMS requests the appropriate QIO (with a contract under Part B of title XI of the Act) to review the alleged section 1867(d) violation and provide a report on its findings in accordance with paragraph (h)(2)(iv) and (v) of this section. CMS provides to the QIO all information relevant to the case and within its possession or control. CMS, in consultation with the OIG, also provides to the QIO a list of relevant questions to which the QIO must respond in its report.

(2) Notice of review and opportunity for discussion and additional information. The QIO shall provide the physician and hospital reasonable notice of its review, a reasonable opportunity for discussion, and an opportunity for the physician and hospital to submit additional information before issuing its report. When a QIO receives a request for consultation under paragraph (h)(1) of this section, the following provisions apply--

(i) The QIO reviews the case before the 15th calendar day and makes its tentative findings.

(ii) Within 15 calendar days of receiving the case, the QIO gives written notice, sent by certified mail, return receipt requested, to the physician or the hospital (or both if applicable).

(iii)(A) The written notice must contain the following information:

(1) The name of each individual who may have been the subject of the alleged violation.

(2) The date on which each alleged violation occurred.

(3) An invitation to meet, either by telephone or in person, to discuss the case with the QIO, and to submit additional information to the QIO within 30 calendar days of receipt of the notice, and a statement that these rights will be waived if the invitation is not accepted. The QIO must receive the information and hold the meeting within the 30-day period.

(4) A copy of the regulations at 42 CFR 489.24.

(B) For purposes of paragraph (h)(2)(iii)(A) of this section, the date of receipt is presumed to be 5 days after the certified mail date on the notice, unless there is a reasonable showing to the contrary.

(iv) The physician or hospital (or both where applicable) may request a meeting with the QIO. This meeting is not designed to be a formal adversarial hearing or a mechanism for discovery by the physician or hospital. The meeting is intended to afford the physician and/or the hospital a full and fair opportunity to present the views of the physician and/or hospital regarding the case. The following provisions apply to that meeting:

(A) The physician and/or hospital has the right to have legal counsel present during that meeting. However, the QIO may control the scope, extent, and manner of any questioning or any other presentation by the attorney. The QIO may also have legal counsel present.

(B) The QIO makes arrangements so that, if requested by CMS or the OIG, a verbatim transcript of the meeting may be generated. If CMS or OIG requests a transcript, the affected physician and/or the affected hospital may request that CMS provide a copy of the transcript.

(C) The QIO affords the physician and/or the hospital an opportunity to present, with the assistance of counsel, expert testimony in either oral or written form on the medical issues presented. However, the QIO may reasonably limit the number of witnesses and length of such testimony if such testimony is irrelevant or repetitive. The physician and/or hospital, directly or through counsel, may disclose patient records to potential expert witnesses without violating any non-disclosure requirements set forth in part 476 of this chapter.

(D) The QIO is not obligated to consider any additional information provided by the physician and/or the hospital after the meeting, unless, before the end of the meeting, the QIO requests that the physician and/or hospital submit additional information to support the claims. The QIO then allows the physician and/or the hospital an additional period of time, not to exceed 5 calendar days from the meeting, to submit the relevant information to the QIO.

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(v) Within 60 calendar days of receiving the case, the QIO must submit to CMS a report on the QIO's findings. CMS provides copies to the OIG and to the affected physician and/or the affected hospital. The report must contain the name of the physician and/or the hospital, the name of the individual, and the dates and times the individual arrived at and was transferred (or discharged) from the hospital. The report provides expert medical opinion regarding whether the individual involved had an emergency medical condition, whether the individual's emergency medical condition was stabilized, whether the individual was transferred appropriately, and whether there were any medical utilization or quality of care issues involved in the case.

(vi) The report required under paragraph (h)(2)(v) of this section should not state an opinion or conclusion as to whether section 1867 of the Act or Sec. 489.24 has been violated.

(3) If a delay would jeopardize the health or safety of individuals or when there was no screening examination, the QIO review described in this section is not required before the OIG may impose civil monetary penalties or an exclusion in accordance with section 1867(d)(1) of the Act and 42 CFR part 1003 of this title.

(4) If the QIO determines after a preliminary review that there was an appropriate medical screening examination and the individual did not have an emergency medical condition, as defined by paragraph (b) of this section, then the QIO may, at its discretion, return the case to CMS and not meet the requirements of paragraph (h) except for those in paragraph (h)(2)(v).

(i) Release of QIO assessments. Upon request, CMS may release a QIO assessment to the physician and/or hospital, or the affected individual, or his or her representative. The QIO physician's identity is confidential unless he or she consents to its release. (See Sec. Sec. 476.132 and 476.133 of this chapter.)

(j) Availability of on-call physicians. (1) Each hospital must maintain an on-call list of physicians on its medical staff in a manner that best meets the needs of the hospital's patients who are receiving services required under this section in accordance with the resources available to the hospital, including the availability of on-call physicians.

(2) The hospital must have written policies and procedures in place--

(i) To respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control; and

(ii) To provide that emergency services are available to meet the needs of patients with emergency medical conditions if it elects to permit on-call physicians to schedule elective surgery during the time that they are on call or to permit on-call physicians to have simultaneous on-call duties.

[59 FR 32120, June 22, 1994, as amended at 62 FR 46037, Aug. 29, 1997; 65 FR 18548, Apr. 7, 2000; 65 FR 59748, Oct. 6, 2000; 66 FR 1599, Jan. 9, 2001; 66 FR 59923, Nov. 30, 2001; 68 FR 53262, Sept. 9, 2003]

Effective Date Note: At 59 FR 32120, June 22, 1994, Sec. 489.24 was added. Paragraphs (d) and (g) contain information collection and recordkeeping requirements and will not become effective until approval
has been given by the Office of Management and Budget.

Oregon CAH External Peer Review Requirements

As of 09/20/05

As stated by Judy Lubeck:

Background – Requirement to Conduct External Peer Review

"I frequently receive questions about peer review. Over the years our office has clarified CMS expectations and interpretations regarding the requirement.

-42 CFR 485.641(b)(4) states that 'The quality and appropriateness of the diagnosis and treatment furnished by the doctors of medicine or osteopathy at the CAH are evaluated by—

(i) One hospital that is a member of the network, when applicable;

(ii) One QIO or equivalent entity; or

(iii) One other appropriate and qualified entity identified in the State rural health care plan.'

This regulation clearly states that the CAH must ensure external peer review. Although most CAHs continue to do some form of internal peer review, the CAH must also ensure a process for external peer review by one of the entities listed in the regulation.

Internal peer review alone would not meet the intent of the regulation.

Number of Records that must be reviewed to Fulfill Requirements

In an e-mail dated 10/29/03 Marjorie Eddinger at CMS Central Office provided the following clarification with respect to the number of records required for external peer review.

"The agreement established between the CAH and the outside review group should establish a % of record reviews. The reviews should satisfy the outside party that they feel the medical care provided is within the scope of acceptable medical care. We [CMS] do not require a 10% review and they [the CAH] could negotiate a lesser amount." The lesser amount was defined as a minimum of one record per year for each physician who provides services in the CAH.

Review Guidelines for Medical Record Documentation

Components of the medical record for which physicians have primary responsibility:

- history and physical examination
- progress notes
- operative report
- discharge summary
- order sheet
- reports of outpatient lab and x-ray

Reasonable evidence of necessity and quality to include:

- analysis of subjective and objective data
- clinical rationale for management decisions
- patient's progress reflected by clinical parameters
- discharge summary to include summary of
- condition admission
- hospital course
- treatment
- condition at discharge
- post discharge plans
- principal diagnosis
- all of the above in a timely, accurate, and complete fashion
- when writing an order, "Do Not Resuscitate", or to perform less than aggressive therapy
- document reasons for the decision
- document the discussion with others involved

CASE REVIEW AGREEMENT

THIS AGREEMENT is made and entered into this ___ day of _____, 2015, by and between the Lake Health District (hereinafter called "LHD") and an Oregon critical access hospital district and _____ (hereinafter called "Hospital.")

WITNESSETH

1. **APPOINTMENT OF LHD:** Hospital hereby appoints and engages LHD and LHD hereby agrees to coordinate Peer Review Services in accordance with the terms and conditions set forth below.

2. **PROCEDURE:** LHD will coordinate Peer Review Services for Hospital, according to the attached LHD Peer Review Network procedures, with a target of completion of medical record review within 45 working days of receipt of medical record from Hospital. The medical reviewer will be asked if he or she has any knowledge of the physician or the case being reviewed and if he or she has any potential conflict of interest. At all times the confidentiality of the patient, the physician being reviewed, the case itself, and the hospital or medical practice, shall be maintained. Actions and reviews done in accordance with this Agreement are intended to be privileged and confidential in accordance with ORS 41.675. After the medical record has been reviewed and the review form has been forwarded to the requesting Hospital, the medical record shall be destroyed within 14 days by LHD Peer Review Coordinator. In addition, the parties shall follow all procedures contained in Attachment A - LHD Peer Review Policy & Procedures. Attachment A is hereby incorporated by reference and made a part of this agreement.

3. **MEDICAL RECORDS CONFIDENTIALITY AND DISCLOSURE:**

The parties agree that they and their designees will:

- Not disclose any confidential medical records other than as may be permitted under this Agreement or as required by law;
- Use appropriate safeguards to prevent use or disclosure of confidential medical records except such use or disclosure as permitted pursuant to this agreement;
- Report to the other party any use or disclosure of confidential medical records not provided for under this Agreement of which it or its designee becomes aware;
- Require any member of the Hospital Peer Review Network or Contract Organization to whom LHD provides the Hospital's confidential medical records to l protect those records in the same manner as provided for in this Agreement and under any applicable state or federal law. LHD further agrees not to provide confidential medical records to any individual not employed by or engaged by LHD without the Hospital's written consent;
- Report to the other party any breach of confidentiality of which the other party becomes aware;
- Upon termination of this Agreement, destroy or return all confidential medical record copies or information belonging to one party and in the possession of the other party and retain no copies of such records or information; and;
- Comply with all legal requirements affecting the use and disclosure of confidential medical information including without limitation any applicable requirements of ORS 41.675

4. **PROFESSIONAL FEE SCHEDULE:** The Hospital agrees to pay LHD according to the following fee schedule:

   Routine (Not-for-Cause) Reviews:

   - LHD Member Facilities
     - Reciprocating (1)
       - A $150.00 per medical record administrative fee will be charged for medical records reviewed through the Hospital Peer Review Network.
     - Non-reciprocating (1)
       - A $275 per medical record review fee will be charged for medical records reviewed through Hospital Peer Review Network.
   - Non-LHD Member Facilities
     - A $325 per medical record review fee will be charged for medical records reviewed through Hospital Peer Review Network.

   Non-Routine ("For Cause") Reviews:

   - LHD Member Facilities
     - Reciprocating (1)
       - A $175.00 per medical record administrative fee will be charged for medical records reviewed through the Hospital Peer Review Network.
     - Non-reciprocating (1)
       - A $300 per medical record review fee will be charged for medical records reviewed through Hospital Peer Review Network.
   - Non-LHD Member Facilities
     - A $600 per medical record review fee will be charged for medical records reviewed through Hospital Peer Review Network.

   (1) "Non-reciprocating" applies to any case review performed for an LHD member facility which does not reciprocate with the specialty under review (performs no reciprocating reviews for like specialty) or which reviews at a sent/reviewed ratio of less than 80% (cases reviewed to cases sent for review) calculated based upon the prior 12-month period.

Second opinion and specialty reviews through a contracted out-of-state Peer Review Network or QIO will be charged at a market rate on a case-by-case basis per medical record.

Payment will be due and payable within 15 days of the Hospital's receipt of review report.

5. **ACTS OR OMISSIONS AND LIABILITY:** Independent medical peer review shall be considered confidential and protected under the Peer Review Statutes of the State of Oregon. ORS 41.675. Hospital shall not hold LHD, medical reviewer, or ORH responsible for any acts or omissions of the medical reviewer in the review of the medical record. Peer Review Services shall be considered a "second opinion" service to assist in hospital quality improvement. LHD and the medical reviewer shall not be held responsible in any way for any action of the Hospital in regard to the physician being reviewed. This paragraph shall survive the termination of this agreement.

6. **TERM OF CONTRACT:** This agreement is for a period of 12 months and will automatically renew at the end of each 12-month period. This Agreement may be terminated at the option of either party at any time by providing thirty (30) days prior written notification of such termination to the other party.
7. **STATUS OF PARTIES:** In the performance of Agreement, LHD shall at all times act in the capacity of an independent contractor, and shall not be deemed to be the agent or employee of the Hospital.
8. **NON-EXCLUSIONARY WARRANTY:** LHD hereby represents and warrants that it has not been excluded from participation in any federally funded healthcare program, including Medicare and Medicaid.
9. **PROVISIONS:** In the event any provision of the Agreement is held invalid, illegal, or unenforceable, in whole or in part, the remaining provisions of this Agreement shall not be affected thereby and shall continue to be valid and enforceable. This Agreement may be executed in multiple copies by the parties hereto. Each multiple or facsimile copy shall be deemed an original, but all multiple copies shall constitute one and the same instrument.
10. **GOVERNING LAW:** The terms and provisions of this Agreement shall be governed by and construed in accordance with the laws of the State of Oregon.
11. **IN WITNESS WHEREOF,** the parties hereto, acting through their duly authorized officers or agent have caused this Agreement to be executed on the day and year first above written.

LHD	***Hospital***
By: _____	By: _____
Title: _____	Title: _____

Critical Access Hospital Case Review
Confidentiality Agreement

As a member of the medical staff or Administrative Staff of _____ I may be involved in the evaluation and improvement of the quality of care within Case Review Member Hospitals. These may include any of the type of activities described in ORS 41.675. I recognize that confidentiality is vital to the free and candid discussions necessary for effective case review quality assurance activities conducted by the Medical Staffs of the Case Review Member Hospitals. Therefore, I agree to respect and maintain the confidentiality of all discussions, reviews, deliberations, records, and other information generated in connection with these activities. I agree to make no voluntary disclosures of such information except to persons authorized to receive information as outlined in our network agreement or within the policies of each individual Network Hospital. Furthermore, my participation in case review and performance improvement activities is in reliance on my belief that the confidentiality of these activities will be similarly preserved by every other member of the Case Review Member Hospitals and those individuals from the Network that are involved in the Case Review Process. I understand that my hospital is entitled to undertake such action as is deemed appropriate to ensure that this confidentiality is maintained, including action necessitated by any breach or threatened breach of this agreement.

- If I receive medical records for purposes of review, I realize medical records may contain protected health information ("PHI") as that term is defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations enacted thereunder.
- I agree to use the PHI received in records only for purposes of assisting with the review for purposes of quality assurance and/or case review.
- I agree to maintain the security and privacy of all PHI in a manner consistent with state and federal laws and regulations, including HIPAA and regulations thereunder, and all other applicable law.
- I agree not to use or disclose the PHI except as expressly permitted by this agreement and applicable law.
- I agree to use appropriate safeguards to prevent disclosure of PHI not permitted by this agreement or applicable law.
- Upon conclusion of my review, I shall return or destroy all PHI received under this Agreement and shall retain no copies of such information.

_____ _____

Staff Member's Signature **Date**

_____ _____

Staff Member's Name Printed **Specialty**

Patient Name:
MRUN:
Date:

EMTALA Transfer Request Form

PHYSICIAN

I authorize/order the transfer of _____ to _____
Name of Patient Receiving Hospital

By this level of transportation: ☐ BLS ☐ ALS ☐ Aircraft ☐ Neonatal unit ☐ Private car
Accompanied by: ☐ None in addition to transport agency personnel ☐ Physician ☐ RN Respiratory Care
With this support/treatment during transfer: ☐ O2: __L/m per _____ ☐ Cardiac monitor ☐ Pulse oximeter ☐ IV pump

☐IV fluids: _____ ☐Restraints ☐ See separate order sheet

Other orders: _____

Report ☐ has ☐ has not been given to _____(**Receiving Physician)** at Receiving Hospital.
Patient Information: **Diagnostic Impression:** _____

Reason for transfer: ☐ Medically indicated ☐ Patient requested ☐ Higher level of care not available here

☐ **Stable:** The patient has been examined and any medical condition stabilized such that, within reasonable clinical confidence, no material deterioration of this patient's condition is likely to result from or occur during transfer.
☐ **Unstable:** The patient has been examined, an Emergency Medical Condition has been identified and the patient is not stable, but the transfer is medically indicated and in the best interest of the patient.

PHYSICIAN CERTIFICATION: I hereby certify that I have examined the patient and based on the information available to me at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical care at another facility outweigh the increased risk to the patient and, in the case of labor, to the unborn child, from effecting the transfer. This certification is based upon the following:

1. **Benefit(s)** of transfer:_____
_____

2. **Risk(s)** of transfer (in addition to deterioration of patient's condition/ clinically specific):
_____
3. Risk(s) of transport: All transfers have the inherent risks of traffic delays, accident during transport, inclement weather, rough terrain or turbulence (if air) and the limitations of equipment and personnel present in the vehicle.
4. I certify that these **risks and benefits have been explained** to the patient.

_____ _____
Physician Name (Print)/Signature **Date/Time**

NURSING

Receiving Hospital Agreed to Accept on (Date/time) _____ Unit/bed/or ED: _____

Report ☐has ☐ has not been given to _____RN at Receiving Hospital.

Name and title of person accepting for receiving hospital: _____
The receiving facility has the capability for the treatment of this patient (including adequate equipment and medical personnel) and has agreed to accept the transfer and provide appropriate medical treatment.

Signature of staff person obtaining the acceptance: _____
ACCOMPANYING DOCUMENTATION: Sent via: ☐ Transporter ☐ Patient or ☐Fax'd to: _____
☐Records available to receiving hospital through shared electronic record.

☐Treatment Notes ☐Lab/ ECG Results ☐Imaging Studies ☐Transfer Form ☐Court Order ☐Other: _____
Nurse Signature: _____ **Date/time:** _____

Patient Name:
MRUN:
Date:

PATIENT

☐ **I CONSENT TO TRANSFER:** I acknowledge by signing this document that **I agree** to be transferred and that hospital staff evaluated my condition and explained it to me. They have recommended that I be transferred to:

Dr. _____ at receiving facility: _____.

The potential benefits of such transfer, the potential risks associated with such transfer, and the possible risks arising from not being transferred have been explained to me to my satisfaction.

X_____ _____
Signature of Patient/ Representative **Date/Time**

_____ _____
Relationship to Patient **Witness**

☐ **I REQUEST TRANSFER:** I hereby request transfer to: _____.
I understand and have considered the hospital's obligations, the risks and benefits of transfer, and the physician's recommendation.
I make this request upon my own suggestion and not that of the hospital, physician, or anyone associated with the hospital.

The reason I request transfer is:
_____.

☐ **I REFUSE TRANSFER:** I acknowledge by signing this document that hospital staff have evaluated my condition and explained it to me, and I have been advised that I require further medical examination and treatment at another hospital. The potential benefits of such further medical examination and treatment as well as potential risks associated with transfer to another facility, and the risks of not receiving the treatment at the proposed receiving hospital have been explained to me and I understand them. In spite of this understanding,

☐ **I refuse the recommended transfer.**

☐ **I REFUSE TREATMENT:** I acknowledge by signing this document that hospital personnel have evaluated my condition and explained to me, and I have been offered further medical examination and treatment. The potential benefits of such further medical examination and treatment as well as potential risks of non-treatment have been explained to me and I understand them. In spite of this understanding,

☐ **I refuse further medical treatment at this hospital and understand that this is against medical advice.**

_____ _____
Signature of Patient/ Representative **Date/Time**

_____ _____
Relationship to Patient **Witness**

☐ **Pt. is unable to sign due to medical reason:**
_____

And there is no proxy decision-maker for the patient available. Staff signature_____

References/Resources

Links

Code of Federal Regulations:
http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfrv3_04.html

CMS Hospital Compare Website:
http://www.hospitalcompare.hhs.gov/

CMS Medicare Benefit Policy manual:
http://www.cms.hhs.gov/manuals/Downloads/bp102c01.pdf

Institute of Healthcare Improvement:
http://www.ihi.org/ihi

Institute of Medicine:
http://www.iom.edu/

National Patient Safety Foundation:
http://www.npsf.org/

OAHHS:
http://www.oahhs.org/

Oregon Statues:
http://www.leg.state.or.us/ors/home.htm

FORMS

The forms contained in the manual are for reference only. To obtain copies of final forms for use, visit the CAHCR website at
http://www.lakehealthdistrict.org/getpage.php?name=Case_Review_Program&sub=Services