AMENDED AND RESTATED  
MEDICAL STAFF BYLAWS  
OF  
The Surgery Center at Lutheran

The governance of the Medical Staff of The Surgery Center at Lutheran ("Center") shall be in accord with these Bylaws promulgated upon recommendation of The Clinical Review Committee ("CRC") and approved by the Board Of Managers ("Board Of Managers"), the Center’s governing body.

ARTICLE I – NAME, PURPOSE, MISSION AND USE OF BYLAWS

Section 1.1 – Name

The Medical Staff of The Surgery Center at Lutheran shall be governed by these Bylaws.

Section 1.2 – Purpose:

The Center is created and operated exclusively for the purpose of providing quality ambulatory surgical care to patients in a facility in which surgical procedures can be safely carried out on an outpatient basis. In line with this purpose, the Center shall:

1. Strive to ensure that all patients treated at its facilities shall receive quality medical care.
2. Strive to ensure a high level of professional responsibility and performance.
3. Initiate and maintain rules of self-assessment and continuous quality improvement.
4. Provide an option for patients' for surgical and other outpatient invasive procedures.
5. Provide directly or indirectly support services that enhance or otherwise contribute to the overall mission and purpose of the Center.

Section 1.3 – Purpose: Medical Staff

The purposes of this Medical Staff are to:

1. Bring the professionals who practice at the Center together into a cohesive body to promote good patient care.
2. Screen and recommend applicants for Medical Staff membership.
3. Review privileges of Members and Allied Health Professionals (AHP).
4. Evaluate and assist to improve the work done by the Medical Staff through participation in the peer review process.
5. Provide education.
6. Provide advice to the Board of Managers.
7. Participate in the development and review of Center Policies.

Section 1.4 – Mission

The Surgery Center at Lutheran provides cost-effective outpatient surgical services using modern, state-of-the-art technology in a friendly and caring environment by highly-skilled, compassionate staff serving Wheat Ridge, CO. and surrounding communities.

Section 1.5 – Use of Bylaws

These Medical Staff Bylaws are expressions of the current requirements of the Center relating to applicants and Members of the Medical Staff; and are subject to change at any time. Members are defined as a Practitioner (physician (MD), doctor of osteopathy (DO), dentist (DDS), doctor of podiatric medicine (DPM) who has a current Medical Staff appointment and who may have clinical privileges granted by the Board of Managers to practice at the Center. These Medical Staff Bylaws do not constitute a contract of any kind whatsoever and any Practitioner who intends that these Bylaws should constitute a contract, must notify the Center and obtain the written consent of the Board. These Bylaws shall be interpreted, applied and enforced within the discretion of the Center as delegated by the Board of Managers.

ARTICLE II – ADMINISTRATION

Section 2.1 – Board of Managers Responsibilities

Board of Managers is ultimately responsible for determining, implementing and monitoring policies governing the Center’s total operation, and for ensuring that these policies are administered so as to provide quality healthcare in a safe environment.

a. Medical Staff: The Board of Managers is ultimately responsible for oversight of the activities of the Center’s Medical Staff. In fulfillment of this responsibility, and upon recommendation by the Clinical Review Committee (CRC), the Board of Managers shall approve the appointments, the granting, restriction or revocation of clinical privileges, all corrective action, and the involuntary termination of staff membership in coordination with the Clinical Review Committee. The Board Of Managers reserves the right to change these Bylaws when, after due course, the Medical Staff has failed to do so when necessary in order to comply with passage of law, change in accreditation standards or other changes in Federal or State laws or statutes.

b. Administration: The Board of Managers is responsible for the appropriate management and administration of the Center. In fulfillment of this responsibility, the Board of Managers shall employ an appropriately qualified, competent Administrator, establish an annual operating budget; and establish such policies as are necessary to properly guide the Center’s operations.

c. Quality Improvement: The Board of Managers is responsible for utilization, quality, appropriateness of procedures, and the appropriateness of medical care rendered by and at the Center. In fulfillment of this responsibility, the Board of Managers shall cause to be established a Quality Improvement Program, which will effectively monitor the quality of care and utilization of facilities with reports of such activities, made to the Board of Managers at least annually.

d. Standards: The Board of Managers is responsible for the maintenance of the Center programs and services in line with community and other appropriate standards. In fulfillment of this responsibility, the Board Of Managers directs that the Center meet and maintain standards for state licensure, participation in the Medicare program and attain accreditation by a nationally recognized organization as appropriate.
Section 2.2 – Administrator

a. Appointment: The Administrator, who may be employed either by an outside management firm or provided directly by the Center, and approved by the Board of Managers, shall be responsible for daily operations of the Center.

b. Responsibilities: With respect to the Medical Staff, the duties of the Administrator include:

1. Execute the mission and goals of the Center.
2. Provide for careful maintenance of patient rights.
3. Assist the Medical Staff in arranging for an appropriately trained, professional staff that provides safe, efficient, quality patient care.
4. Assist the Medical Staff in developing Quality Improvement, Risk Management and Peer Review programs in accordance with applicable standards.
5. Ensure that all provisions are made for ancillary services including laboratory, radiology, and pathology services; and assure that appropriate transfer agreements have been entered into with local hospitals.
6. Ensure that the organization does not discriminate on the basis of race, creed, sex, national origin or religion.
7. Formulate short and long-range plans in accordance with the missions and goals of the Center.
8. Serve as management's representative to the CRC.
9. Management oversight over fiscal and contracted services matters as it pertains to daily operations of the Center.

Section 2.3 – Medical Director

a. Appointment: The Medical Director shall be appointed by the Board of Managers and shall serve until replaced. The Medical Director shall perform the duties specified within his or her Medical Director contract with The Surgery Center at Lutheran, and by these Bylaws.

b. Responsibilities: The Medical Director is invested with the following duties and prerogatives, subject to the discretion of the Board of Managers:

1. Facilitate Clinical Review Committee (CRC) meetings.
2. Serve as a voting member of the CRC.
3. Facilitate adherence of the Medical Staff to these Bylaws.
4. Be chief spokesperson and enunciator of policy for the Medical Staff.
5. Monitor adherence to policies with respect to patient rights.
6. Assist the Administrator in arranging for an appropriately trained, professional staff capable of providing safe, efficient, quality patient care.
7. Assist the Administrator in developing a structure that clearly delineates the authority and responsibility of the Medical Staff within the organization.

8. Take the initiative in developing appropriate policies and procedures for the safe, effective conduct of business and provision of patient care; and review all clinical policies and procedures of the Center. The Medical Director shall be specifically authorized to approve (after consultation with the appropriate CRC Specialty representatives) and implement policies and procedures (subject to such subsequent CRC review and ratification, as the CRC Specialty representative deems advisable).

9. Take the initiative in developing for consideration by the Medical Staff, Quality Improvement, Risk Management and Peer Review programs in accordance with applicable state and/or federal regulations & accreditation standards.

10. Advise the Administrator in arranging for ancillary services including laboratory, radiology, and pathology services.

11. Carry out all other duties specifically entrusted to him/her by the CRC.

ARTICLE III – MEDICAL STAFF MEMBERSHIP AND PRIVILEGES

Section 3.1 – Purpose and Responsibilities

The Board of Managers has created a Medical Staff organization, to be known as The Lutheran Surgery Center Medical Staff ("Medical Staff"), whose membership shall be comprised of all Practitioners given privileges to attend patients at the Center. The Board of Managers, by creation of the Medical Staff in these Bylaws provides a structure whereby the members can become an integral part of the organization and participate in the policy setting and decision making processes related to patient care. The Board of Managers delegates to the Medical Staff such responsibility to regulate matters relating to Medical Staff membership status, clinical privileges, and corrective action, as is provided in these Bylaws; and the Medical Staff delegates to its Clinical Review Committee and Patient Care Committees (or such ad hoc committees as may be appointed in accordance with these Bylaws) the authority and responsibility to carry out their respective responsibilities including, but not limited to:

a. Reviewing, analyzing, and evaluating clinical practices to determine the quality of medical care.

b. Making recommendations to the Administrator for establishment, maintenance and continuing improvement and enforcement of professional standards.

c. Recommending the appointment and reappointment of qualified Practitioners to the Medical Staff and delineation of clinical privileges.

d. Recommending the granting of clinical privileges to qualified Allied Health Professionals (provided that category of AHP has been approved for practice in the Center by the CRC and Board of Managers).

e. Recommending the discipline of Medical Staff members and AHPs for violation of these bylaws, federal or state laws, and any policy of the Center within the limitation of the authority delegated by the Board of Managers.
Section 3.2 – Nature of Membership

a. Membership on the Medical Staff is a privilege, which shall be extended only to mentally and physically healthy, professionally competent, and appropriately licensed physicians, osteopaths, podiatrists and dentists who meet the qualifications as set forth in these Bylaws.

b. Acceptance of membership on the Medical Staff shall constitute the staff member’s agreement that he/she will abide by the Bylaws, Rules and Regulations and the Policies and Procedures of the Center as they may be amended from time to time; participate cooperatively in peer evaluation activities (both as a committee member and in conjunction with evaluation of his/her own performance or professional qualifications); and obtain appropriate informed consent as required for each medical intervention contemplated.

c. Acceptance of membership on the Medical Staff shall constitute the staff member’s agreement that he/she will abide by the principles of medical ethics.

d. Acceptance of membership on the Medical Staff shall constitute the staff member’s acknowledgement and agreement that he/she has filed a current and proper address of record with, and shall immediately notify the Center and the appropriate State licensing agency (e.g., State Medical Board, Board of Podiatric Medicine, Board of Dental Examiners of any changes in, his/her address of record, giving both the new and old address. Applicants requesting privileges to the Medical Staff of the Surgery Center at Lutheran shall acknowledge and utilize the appropriate corresponding credentialing application form mandated by the Colorado Department of Public Health and Environment (§ CCR 1014-4), entitled as the Colorado Health Care Professional Credentials Application. This form is to be used by any type of healthcare professional who is registered, certified or licensed by the state of Colorado, who practices or intends to practice in Colorado and who is subject to credentialing.

e. Appointment and/or clinical privileges on the Medical Staff of The Surgery Center at Lutheran shall not be denied or altered on the basis of sex, race, creed, color, national origin, or religion.

f. Allied Health Professionals are subject to the requirements of these Bylaws; however, they are not deemed members of the Medical Staff, and are not afforded the procedural rights set forth in these Bylaws with respect to Fair Hearings.

Section 3.3 – Qualification for Physician Membership

Any physician seeking Medical Staff membership or any established Medical Staff member shall possess the following qualifications:

a. Shall be a graduate of a recognized medical or osteopathic school with a current MD or DO degree.

b. Shall hold a current license from the appropriate Professional Licensing Board of the State of Colorado.

c. Shall have a current DEA license. (Additionally, a copy of the required corresponding State Pharmacy licensure will also be needed, if applicable).

d. Shall have and continue to maintain unrestricted privileges at a local Medicare-participating hospital or provide a documented agreement in place with a medical physician for hospital admission and follow-through care of the patient.
e. Shall document background, experience, and training (copies of certificates from medical school, internship, residency and when applicable, Board Certification are optional; corresponding verification for these must be performed) and demonstrate adherence to the ethics of the profession.

f. Shall possess the character and ability to work cooperatively and effectively with the Center employees and Medical Staff for the welfare of the Center's patients and to deliver high quality care.

g. Shall carry professional liability insurance with a qualified carrier with minimum limits as determined by the Board of Managers. (1 Million/3 Million)

h. Shall maintain an active practice of medicine within the local community, such physician shall maintain active privileges at this Center and at least one hospital within fifty (50) miles of the Center and shall provide professionally qualified on-call coverage for his/her patients who have had surgery at the Center.

Section 3.4 – Qualifications for Anesthesiologist

Anesthesiologists shall meet the above-stated qualifications for Physician Membership; however, the following exceptions or additional requirements apply:

a. Competent and qualified anesthesiologists will provide anesthesia services.

b. Anesthesiologists need not maintain hospital privileges.

c. Anesthesiologists shall abide by the American Society of Anesthesiologists Standards of Care and shall also abide and follow, but not by way of limitation, the anesthesia policies and procedures of the Center.

Section 3.5 – Qualifications for Dental Membership

Any dentist seeking Medical Staff membership shall possess the following qualifications:

a. Shall be a graduate of a school of dentistry with a DDS or equivalent degree from an accredited school of dentistry approved at the time of issuance by the State Dental Board.

b. Shall hold a current license to practice dentistry in the State of Colorado.

c. Shall have a current DEA license. (Additionally, a copy of the required corresponding State Pharmacy licensure will also be needed, if applicable.)

d. Shall document background, experience, and training, and demonstrate adherence to the ethics of the profession.

e. Shall possess the character and ability to work effectively with the Center employees and Medical Staff for the welfare of the Center's patients and to deliver high quality care.

f. Shall carry professional liability insurance with a qualified carrier with minimum limits as determined by the Board of Managers. (1 million/3 million)

g. Shall provide professionally qualified on-call coverage for his/her patients who have had surgery at the Center.
h. Shall have and continue to maintain unrestricted privileges at a local Medicare-participating hospital limited to their scope of practice or provide a documented agreement in place with a medical physician for hospital admission and follow-through care of the patient.

Section 3.8 – Qualifications for Podiatry Membership

Any podiatrist seeking Medical Staff membership and any podiatrist Medical Staff member shall possess the following qualifications:

a. Shall be a graduate of a podiatry school and hold a DPM degree approved by the State Board of Podiatric Medicine at the time of issuance.

b. Shall hold a current license to practice podiatry in the State of Colorado.

c. Shall have a current DEA license. (Additionally, a copy of the required corresponding State Pharmacy licensure will also be needed, if applicable.)

d. Shall document background, experience, and training, and demonstrate adherence to the ethics of the profession.

e. Shall have and continue to maintain unrestricted privileges at a local Medicare-participating hospital limited to their scope of practice or provide a documented agreement in place with a medical physician for hospital admission and follow-through care of the patient.

f. Shall possess the character and ability to work effectively with Center employees and Medical Staff for the welfare of the Center’s patients and to deliver high quality care.

g. Shall carry professional liability insurance with a qualified carrier with minimum limits as determined by the Board of Managers.

h. Shall provide professionally qualified on-call coverage for his/her patients who have had surgery at the Center.

Section 3.7 – Qualifications for AHPs

The CRC may promulgate policies and procedures setting forth minimum qualifications, sponsorship and supervision requirements, and delineation of privileges and/or scope of practice, and applicable performance standards for those categories of AHPs who are allowed to perform clinical procedures at the Center. In the absence of formal policies and procedures, the CRC shall be authorized to exercise reasonable discretion in granting AHP privileges, setting forth sponsorship and supervision requirements, and establishing scope of practice and applicable performance standards in this Center. In no event shall an AHP be allowed to provide patient care services without confirmation of such licenses and permits as may be required by law, or without being covered by acceptable levels of malpractice liability insurance as determined by the Board of Managers.

Section 3.8 – Categories of Medical Staff Membership

Any Practitioners appointed or re-appointed to Medical Staff membership shall be appointed in accordance with their specialty in the following Medical Staff categories:

a. **Active Staff** shall consist of Practitioners (MD, DO, DDS, DPM) maintaining unmonitored Medical Staff privileges at the Center.

b. **Temporary Staff** shall consist of Practitioners (MD, DO, DDS, DPM). (Temporary is defined in Section 3.15(a).)
Section 3.9 – Duration of Initial Appointment to Medical Staff

Initial appointments shall be to the Active Staff. The initial appointment shall be for two years. At least 90 days before the end of that term, the Practitioner must apply for reappointment. A courtesy letter will be sent out at 180 days to remind Practitioners. This includes timely submission of required documents (refer to Section 3.12).

Section 3.10 – Procedure for Initial Appointment to Medical Staff

a. **Content of Application:** A completed application packet for appointment shall include, but not be limited to, the following:

1. A signed and completely filled out application for appointment, using the prescribed form.

2. A signed consent authorizing the Center to complete a background investigation of his/her qualifications for staff membership.

3. A signed release from liability for any person or organization providing relevant information in good faith concerning the applicant’s qualifications.

4. A signed and completed request for delineation of privileges (DOP).

5. Adequate documentation to satisfy status:
   
   (a) Current license issued by the appropriate Professional Licensing Board in the State of Colorado.

   (b) Current DEA license (additional copies of the required corresponding State pharmacy licensure will be needed, if applicable).

   (c) Current proof of insurance with limits as established by the Board of Managers.

   (d) Copies of certificates of education, residency and professional training are optional; corresponding verification for these must be done.

   (e) As applicable, copies of certificates of specialty or subspecialty coursework (optional if verification is done).

   (f) Such other information as the CRC determines relevant to reasonable and evaluation of the applicant’s qualifications. This includes but is not limited to: documentation of current proficiency in the requested procedures (as evidenced by adequate training in and/or performance of the requested procedures during the immediately preceding two years), Two (2) Peer References, documentation of other health care facility appointments and professional society affiliations.

b. **Submission of Application:** The applicant shall submit the completed application packet, including signature and supporting materials to the designated credentialing service and/or personnel, who shall receive the application as the agent of the CRC. The designated credentialing service and/or personnel shall check the application for completeness, and shall then promptly forward it to the Administrator and/or Medical Director.
c. **Investigation of Applicant:** The Administrator, with the assistance of the Medical Director and a CRC representative (as needed & appointed by the Medical Director) shall make a thorough investigation of the applicant's qualifications. This investigation may include (but not by way of limitation):

1. Personal Interview:

2. Verification of hospital Medical Staff membership for admitting privileges and follow-up consultation with members of the Medical Staffs of hospitals and other persons or organizations with which the applicant has been associated;

3. Documents and records review:

4. Verification of malpractice insurance and query of the applicant's malpractice claims history:

5. Primary and/or secondary source verification. (A query to the American Medical Association and/or National Practitioner Data Bank, OIG and others as may be indicated).

5. Completion of the section on the prescribed Application form, documenting the physical and/or mental health status as it relates to his/her ability to fulfill the requirements of Medical Staff membership and patient care.

d. **Report of Investigation:** Once the application is deemed complete by the CRC, within a reasonable period of time (generally 4-6 weeks) following receipt of the completed application and supporting documents, the Administrator or designated credentialing service shall compile and review application documents and then forward to the Medical Director and corresponding specialty CRC member for the same purpose.

e. **CRC Recommendation:** At its next regularly scheduled CRC meeting, the CRC shall determine whether to recommend that the applicant be appointed and what clinical privileges the applicant should be granted. If the recommendation is to deny the application, or to grant some but not all of the clinical privileges requested by the applicant, the applicant shall have such procedural rights as may be set forth in the Fair Hearing Plan in Article IV.

f. **Notice of Final Decision:** The applicant shall receive timely written notification from the Board of Managers regarding the results of privileging. Any notification of appointment shall state the clinical privileges to be granted the applicant.

g. **Burdens of Submitting and Processing Information:** The burden of submitting a complete application (including but not limited to all documentation, references or supplemental information reasonably necessary for the CRC to make a responsible and sound recommendation) shall be upon the applicant. Until an application has been deemed complete by the CRC, it shall not be processed. Once a deemed complete application has been submitted and any necessary verification received, the burden rests upon the Center and Medical Staff to be prompt and timely in its procedures. Any delay or deferment by the Center or Medical Staff must be for good cause. If appropriate by law, and subject to the applicant submitting a deemed complete application demonstrating qualifications for membership on the Medical Staff, the applicant may be eligible for temporary privileges with approval by the medical director and at least one (1) additional member of the CRC. Eligibility for temporary privileges may only be afforded in circumstances that are beyond the control of the applicant (for example, should a delay occur due to scheduling difficulties of CRC or Board Of Managers) upon receipt of an application and all supporting materials deemed complete by the CRC.
h. **Proctoring:** Proctoring may be used at the discretion of the CRC to validate a medical staff member's capabilities at anytime or within a specific length of time deemed necessary to complete the assessment. The specific proctoring requirements shall be subject to tailoring in the discretion of the Medical Director or CRC, as appropriate to the clinical procedures involved and the applicant's qualifications. Proctoring reports may be accepted from other institutions provided they are completed in sufficient detail as to enable reasonable opportunity to assess the applicant's performance. The medical staff member will be required and held accountable for obtaining his/her own acceptable and qualified proctor.

**Section 3.11 – Duration of Reappointment to Medical Staff**

The qualified Practitioner needs to complete the required initial time frame, which is two years. At least 90 days before the end of that term, the Practitioner needs to apply for reappointment. A courtesy letter will be sent to the practitioner 180 days before the end of their term as a reminder. The duration of reappointment for a qualified Practitioner of the Medical Staff shall be for two years. Timely submission of appropriate documents must be acquired for the reappointment application to be complete. (Refer to Section 3.12).

This process should continue in the same manner for each consecutive reappointment thereafter. Individual peer-based review shall be integrated during each reappointment for all Practitioners; the results will be used as part of the basis for granting continuation of clinical privileges. The peer review process remains an integral part of the facility's quality management and improvement program. (This peer review process shall be the same as described in Section 3.12b).

**Section 3.12 – Procedure for Reappointment to Medical Staff**

At least 90 days before the end of the current term, the Administrator shall provide the Medical Staff member the appropriate information and forms required for reappointment. Change in health or mental status and the filing and service of any professional liability complaints must be reported. Failure to return the reappointment application within 60 days may result in termination of Medical Staff privileges. The following information is required for submission in order for the reappointment process. Only those reapplications deemed complete shall be eligible for review, and the process to commence:

a. **Re-applicants Need to Submit:**

1. A completed reappointment form.

2. A signed 'release from liability' statement for any person or organization providing relevant information in good faith concerning the applicant's qualifications.

3. A current delineation of privileges.

4. Copy of current Federal DEA (and State Pharmacy License, as applicable)

5. Copy of current professional licensure.

6. Current proof of malpractice insurance with limits as established by the Board of Managers.

7. Copies of any additional certificates of education, certification, specialty/subspecialty coursework, etc., since previous appointment is optional; corresponding verification for these must be done.

8. Such other information as the CRC and Board of Managers determines relevant to reasonable for evaluation of the re-applicant's qualifications.
Additionally, primary source and/or secondary source verification will be included in this process. A query to the National Practitioner Data Bank may be performed as indicated. If no written transfer agreement exists between this facility and a nearby hospital then additional verification should include that the re-applicant has admitting privileges at a nearby hospital. The above process should continue in the same manner for each consecutive reappointment thereafter.

b. **Peer Review by the CRC:** The CRC shall review the performance of each member requesting reappointment at the next regularly scheduled meeting. The following criteria are used to gauge the current member’s competency (details of criteria used shall be determined by the CRC and Board of Managers), include but not limited to:

1. **Performance.**
2. **Judgment,** including but not limited to, the individual’s physical and mental capacity to render care for privileges granted.
3. **Technical skill.**
4. **Other information pertaining to various Peer Review indicators that involve important aspects of care such as indications for surgery, appropriateness of care, infection control, transfers, etc., may be considered.** Any information obtained through the peer review process is confidential and shall be treated as such. The member shall be required to provide documentation of physical and/or mental health status and to submit to such health examinations (urine drug screening and/or blood alcohol testing) as deemed necessary by the CRC and/or Board of Managers.

c. **Recommendation of the CRC:** Upon making a recommendation to re-appoint a member, the CRC shall also recommend the clinical privileges to be granted.

d. **When Reappointment is Effective:** Any reappointment, category of membership, or clinical privileges granted with reappointment shall be effective immediately upon approval of the Board of Managers so that there will not be interruption of privileges.

e. **Failure to Renew Membership:** If a Practitioner does not renew his/her membership and is removed from Active Staff status, he/she must complete and follow the procedure for Initial application for appointment as set forth in Section 3.10 of the Bylaws in order to regain staff membership.

**Section 3.13 – Clinical Privileges**

No clinical privilege exists unless specifically granted pursuant to these Bylaws. Privileges will generally not be granted in excess of those enjoyed by the Practitioner at a local Medicare-participating hospital. Exceptions to this policy may be made where the service is not available at the local hospital (e.g., laser privileges). Privileges may not be granted for a period longer than two years and may be reviewed and modified at any time pursuant to these Bylaws.

**Section 3.14 – Newly Established Procedures**

The CRC shall certify competence in newly established procedures based on the staff member’s documented training and experience prior to allowing the procedure to be performed unsupervised. Extraordinary supervision arrangements may be implemented (e.g., supervision in another facility by non-Medical Staff members), may be allowed where it is not possible to arrange for supervision within the Center due to the newness of the procedure. Prior to such certification, the procedure will not be listed as a permitted procedure in a staff member’s medical privileges file.
Section 3.15 – Temporary Clinical Privileges

a. Temporary Privileges shall be those granted to Practitioners pending processing of their application for regular Medical Staff membership and shall enable the person granted such privileges to admit and/or treat an unlimited number of patients (except as may be specifically limited by the CRC).

b. **Purpose:** Temporary Privileges are intended to augment the normal process for granting new privileges and are not a replacement for that process. As such, the expiration of or failure to grant Temporary Privileges shall not constitute a cause for access to the Fair Hearing Process unless applicable State law requires it. All requests for Temporary Privileges shall also constitute a request for the same privileges through the normal process.

c. **Authority:** The Medical Director, in consultation with the specific CRC specialty representative, may issue Temporary Privileges, upon receipt of a completed application as outlined in Section 3.10(a), 3.10(b), and 3.10(c) of these Bylaws, including but not limited to the following items: current license, current DEA permit (if required), current evidence of malpractice insurance. The applicant must demonstrate solid standing in the medical community and has demonstrated that he/she has comparable privileges at and regularly and routinely performs similar procedures in at least one local Medicare-participating hospital.

d. **Duration:** Temporary Privileges may only be granted for a specific time period. The specific time period for these may not exceed 90 consecutive calendar days.

Section 3.16 – Emergency Privileges

In an emergency, any physician, dentist, or podiatrist attending a patient may perform medical services within his/her licensure to advance the best interest of the patient, regardless of any limitations imposed by these Bylaws. When the emergency situation no longer exists, the Practitioner must obtain the privileges necessary to treat the patient pursuant to these Bylaws if the Practitioner desires to continue treating such patient. For purposes of this Section, an emergency is defined as a situation in which there is immediate danger of loss of life or a permanent or serious disability in which any delay in treatment might increase that danger.

Section 3.17 – Continuing Applicability

The requirements and qualifications for Medical Staff membership are continuing provisions that must be met throughout the duration of any period of appointment or reappointment. Therefore, all provisions (such as obligations to provide information, to resolve doubts, or to demonstrate satisfactory compliance with various requirements of these Bylaws) shall apply any time the CRC deems it necessary to reevaluate a member's continued qualification for membership or privileges.

Section 3.18 – Waivers

Insofar as consistent with applicable laws and accreditation requirements, any qualification, requirement, or procedure may be waived at the discretion of the Board of Managers upon determination that such waiver will serve the best interests of the patients and the Center.

Section 3.19 – Limiting Size of Staff

The Board of Managers may, upon recommendation of the Medical Director or the CRC, in consultation with the Administrator, limit the number of Practitioners allowed to practice at this facility (by specialty or altogether) to such number as deemed reasonable within the Center’s capabilities with respect to considerations such as efficiency, number of operating rooms, available support staff, and ability to schedule procedures within a reasonable time of request.
Section 3.20 – Denial of Appointment, Reappointment, or Clinical Privileges

a. **Procedural Rights:** Upon making a recommendation not to appoint/re-appoint a member, or upon a decision to deny some or all of the clinical privileges requested by a member being re-appointed, the affected Practitioner shall be entitled to such procedural rights as may be afforded by the Fair Hearing Plan in Article IV of these Bylaws.

b. **Reporting:** The National Practitioner Data Bank and the State Professional Licensing Board shall be notified of any final decision regarding membership or privileges which can be considered an adverse action, as defined in Article IV, Section 4.1 of these Bylaws, or which is otherwise defined or reportable pursuant to applicable Federal or State law.

Section 3.21 – Cessation of Clinical Privileges and/or Medical Staff Membership

Medical Staff membership and/or clinical privileges shall cease upon the occurrence of any of the following events:

a. **Voluntary Withdrawal from Membership by a Member:** The clinical privileges and Medical Staff membership of any member voluntarily withdrawing from membership shall end automatically. Any clinical privileges granted a member shall cease upon receipt by the CRC of the member’s written notification of voluntary relinquishment of such privileges.

b. **Non-Reappointment to Medical Staff Membership:** The clinical privileges and Medical Staff membership of any member not re-appointed or not in the process of consideration for reappointment, including all applicable hearing and appellate review processes, shall cease upon the expiration of the member’s current appointment.

c. **Termination of Medical Staff Membership and Clinical Privileges:** Termination of Medical Staff membership and/or clinical privileges after waiver or exhaustion of all applicable hearing and appellate review processes.

d. **Failure to Meet Minimum Service Requirement:** The Board of Managers has established certain conditions and requirements which must be met in order to remain eligible to hold “active membership” privileges at the Center, including, without limitation, requirements designed to ensure that active members of the medical staff are performing sufficient procedures to allow for evaluation of the quality of care provided. For purposes hereof, an “active member of the medical staff” shall be an individual who has performed a minimum of fifty procedures in their specialty, twenty four (24) procedures which must be done in the Center during the immediately preceding twenty four (24) month period (twelve [12] procedures per each 12-month period). The Center shall evaluate whether an individual meets such requirements on an annual basis beginning with the first (1st) anniversary of a physician’s obtaining active medical staff membership. In the event that a physician has not performed the required number of procedures, then such physician’s medical staff privileges shall terminate.

Section 3.22 – Suspension of Medical Staff Membership and/or Clinical Privileges

Medical Staff membership and/or clinical privileges shall be suspended for the following reasons:

a. **Automatic Suspension:** Medical Staff members are required to immediately report, to the Medical Director, the occurrence of any of the actions listed in subparagraphs 1 through 4, below. A Medical Staff member’s membership and clinical privileges shall be automatically suspended or restricted if:

1. The State Professional Licensing Board or the DEA revokes, suspends or restricts a member’s license or DEA permit.
2. His/her admitting and clinical privileges at a local Medicare-participating acute care hospital are revoked, suspended or restricted.

3. He/she fails to maintain malpractice insurance at such levels as required by the Board of Managers.

4. He/she fails, at the end of each term of his/her appointment (whether as an Active or Temporary appointee), to provide documentation of current license, current DEA permit, and current evidence of malpractice insurance, as required by these Bylaws.

5. Failure to Respond to CRC Correspondence: Practitioners failing to respond to CRC and the Center correspondence may, at the discretion of the CRC, have their privileges suspended until such time as they answer the requested correspondence.

b. Procedural Rights. A Practitioner, whose Medical Staff membership and/or clinical privileges are automatically diminished, restricted, suspended, revoked or limited pursuant to this Section 3.22, shall not be entitled to the procedural hearing and appellate review rights set forth in these Bylaws.

A Practitioner whose Medical Staff membership and/or clinical privileges are automatically suspended shall be entitled to submit a written request within five (5) working/business days for reinstatement to the Medical Staff and the Administrator with documented proof that the deficiencies leading to the suspension have been corrected. If documented proof that the deficiency has been corrected is provided to the satisfaction of the Medical Staff and Administrator and the request for reinstatement is denied, the Practitioner is entitled to the procedural rights provided in these Bylaws and, not later than the end of the fifth working day after the date reinstatement was denied, the Administrator shall give the affected Practitioner notice of the denial of his/her request for reinstatement and a summary of his/her procedural rights as provided in these Bylaws.

Notice. The Administrator shall give a Practitioner who is automatically suspended written notice of such automatic suspension no later than the end of the fifth working day after imposition of such automatic suspension by the Administrator. Such notice shall state the reasons for such automatic suspension and refer the Practitioner to the Bylaws for the process to be followed to release the automatic suspension and his/her procedural rights, if applicable. Additionally, such written notice maybe sent by a tracking courier service and/or hand delivered.

c. Investigatory Suspension (or Precautionary Suspension): An Investigatory suspension may be imposed for a period of no more than fourteen days to allow for investigation and consideration of whether there is a need for potential professional review corrective action. Imposition of an Investigatory suspension shall not entitle the Practitioner to any procedural hearing or appellate review rights. An Investigatory suspension must either be terminated by the end of the fourteenth day or be converted, if warranted, to a summary suspension.

d. Summary Suspension:

1. A Practitioner shall face summary suspension of Medical Staff membership or all or some of his/her privileges (i) whenever the failure to take such action may result in an imminent danger to the health of any individual within the facility; (ii) if a Practitioner fails to report a matter required to be reported pursuant to Section 3.22a, above; or (iii) if the Practitioner has falsified medical records or otherwise engaged in a significant and willful violation of law, regulation, or these Bylaws. The CRC hereby authorizes summary suspension to be imposed by the Medical Director, the Administrator or any member of the Board of Managers. Such
summary suspension shall become effective immediately upon imposition by the authority imposing such suspension, which shall promptly give notice of the suspension to the affected Practitioner, the Board of Managers, the Medical Director, CRC, and the Administrator.

2. In the event a summary suspension is initiated:

(a) A written report of the suspension of membership and/or privileges shall be completed and delivered by the end of the following business day to the affected Practitioner and to the CRC, stating the reason for imposing the suspension.

(b) The CRC shall, within 15 calendar days of the written report of the suspension of membership, shall consider at which time they may sustain, end, or modify the suspension. The CRC shall also recommend such permanent adverse action, as it deems appropriate under the circumstances. At the discretion of the CRC, the affected Practitioner may be required to attend such portion of this meeting as deemed necessary to answer questions and/or provide additional information to the CRC.

(c) If the CRC sustains or modifies the suspension and/or recommends imposition of any permanent adverse action, the Practitioner shall have such procedural rights as may be afforded pursuant to the Fair Hearing Plan set forth in Article IV of these Bylaws.

(d) Upon completion (or waiver) of procedural rights, the CRC shall immediately forward the recommendation to the Board of Managers for immediate and final decision.

Section 3.23 – Routine Corrective Action

a. **Request:** Whenever a Practitioner engages in acts, statements, demeanor, or unprofessional conduct, either within or outside the Center (as more specifically described in subsection 3.23b below, and the same is, or is reasonably likely to be detrimental to patient safety or to the delivery of quality patient care, disruptive to facility operations, demeaning to the facility staff, Medical Staff or medical profession, or an impairment to the community’s confidence in the facility, a request for corrective action against such member may be initiated by the Medical Director, any member of the CRC, the Administrator, or any member of the Board of Managers. Corrective action may also be initiated whenever it appears that a member no longer meets the current requirements of Medical Staff membership and/or clinical privileges.

b. **Grounds for Corrective Action:** Grounds for corrective action shall include, but shall not be limited to, the following:

1. Professional conduct deemed lower than the standards of the Medical Staff by the CRC/Board of Managers (Governing Board), to include but not limited to that which reflects negatively on the reputation of the Medical Staff or the Center.

2. Unethical practices, inclusive of, but not limited to, violations of the regulations under Medicare for fair billing practices, and/or violations of Colorado Law.

3. Conviction of a felony.
4. Deviation from the standard of care within the community, as identified by the CRC/Board of Managers (Governing Board) with consultation from appropriate specialties, as necessary.

5. Incompetence.

6. Failure to keep adequate records or falsification of records.

7. Violation of these Bylaws of the Medical Staff, the Rules and Regulations, or Center policies and procedures.

8. Demonstrated rude or disrespectful attitudes toward patients, staff, co-workers, or Center personnel (including but not limited to disruptive behavior and/or sexual harassment).

9. Off-the-job actions or inactions that may adversely affect the individual’s job performance, the Center’s teamwork, or the reputation of the Center.

10. Use of illegal drugs.

11. Use of alcohol or legal drugs to the extent that performance or behavior may be adversely affected.

c. **Investigation and Report:** The CRC (or its designated representative) shall direct such investigation, as it deems appropriate. The CRC (or its designated representative) may require the Practitioner to appear and answer questions and/or provide information in conjunction with the investigation. Except as may be delayed for good cause, the investigation should generally be conducted and completed within 30 days. The CRC shall compile a written report of the investigation and any recommended corrective action to the Board of Managers. A copy of this report shall also be forwarded to the affected Practitioner.

d. **Recommended Actions:** Initiation of corrective action may result in one or more of the following recommendations by the Board of Managers;

1. Rejection of the request for corrective action.
2. A warning, a letter of admonition, or a letter of reprimand.
3. Imposition of probation or individual requirements of consultation.
4. Denial, suspension, revocation, or restriction of some or all of the Practitioners clinical privileges.
5. Limitation of any staff prerogatives directly related to the member's delivery of patient care.
6. Suspension or revocation of membership on the Medical Staff.

e. **Procedural Rights:** When the CRC issues any recommendations that meet the description of an "adverse action" as described in Section 4.1 below, the matter shall be subject to review according to the Fair Hearing Plan in Article IV, before final action by the Board of Managers.

f. **Corrective Action for AHPs:** Except as otherwise set forth in specific provisions of these Bylaws, the Rules and Regulations, or policies and procedures established with respect to AHPs, the Administrator in consultation with the Medical Director shall be primarily
Section 3.24 – Federal and State Reporting

The National Practitioner Data Bank and the Medical Board of Colorado shall be notified of any final decision regarding membership or privileges, which is reportable pursuant to applicable Federal or State law.

ARTICLE IV – FAIR HEARING PLAN

The provisions in these Bylaws for a Fair Hearing Plan are provided in accordance with State and Federal mandates. If State or Federal statutes, laws, or regulations change, are in conflict with the established Fair Hearing Plan of these Bylaws, the State and/or Federal statutes, laws, and regulations take precedence over those initiated in these Bylaws, with the established Bylaw guidelines in question becoming null and void. Except as otherwise specifically required by law, this Fair Hearing Plan shall not apply to AHPs requesting or exercising privileges at the Center. Procedural rights for those categories of AHPs shall be subject to the discretion of the Center’s Administrator, in consultation with the Medical Director or Clinical Review Committee.

Section 4.1 – Initiation of Hearing

a. Recommendations or Actions: The following recommendations or actions shall, if deemed adverse pursuant to Section 4.1b of these Bylaws, entitle the affected Practitioner to a hearing:

1. Denial of initial Medical Staff appointment.
2. Denial of Medical Staff reappointment.
3. Summary suspension of Medical Staff membership as sustained or modified by the CRC.
4. Revocation of Medical Staff membership.
5. Limitation of any staff prerogatives directly related to the member's delivery of patient care.
6. Denial of requested clinical privileges.
7. Reduction in clinical privileges.
8. Summary suspension of clinical privileges (but not automatic or investigatory suspension).
9. Revocation of clinical privileges other than pursuant to Section 3.21(d).
10. Imposition of individual requirements of intra or pre-treatment consultation/proctoring.

b. Adverse Recommendations or Actions: A recommendation or action listed in Section 4.1a shall be deemed adverse only when it represents an action that must be reported to the State Professional Licensing Board or the National Practitioner Data Bank, and it has been:

1. Taken or recommended by the CRC upon its own initiative, or following recommendation of the Patient Care Committee; or
2. Taken or recommended by the Board of Managers upon its own initiative.

c. Notice of Adverse Recommendation or Action: A Practitioner against whom an adverse action has been taken or recommended pursuant to Section 4.1b shall promptly be given notice of the action or recommendation. The notice shall be delivered in person or by registered or certified mail, and shall:

1. Advise the Practitioner of his or her right to a hearing pursuant to the provisions of the Bylaws of the Center, including this Fair Hearing Plan, and also provide a general description of the reasons for the recommendation or action.

2. Specify 30 days following the date of receipt of notice within which a request for a hearing must be submitted.

3. State that failure to request a hearing within the specified time period shall constitute a waiver of rights to a hearing and to an appellate review on the matter and acceptance of the recommendation or action.

4. State that upon receipt of the hearing request, the Practitioner will be notified of the date, time, and place of the hearing, and the grounds upon which the adverse action is based.

5. Provide the following summary of rights in the hearing:
   
   (a) To representation by an attorney or other person of the physician's choice;
   
   (b) To have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof;
   
   (c) To call, examine, and cross-examine witnesses;
   
   (d) To present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and;
   
   (e) To submit a written statement at the close of the hearing, and

6. Upon completion of the hearing, the physician involved has the right

   (a) To receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and;

   (b) To receive a written decision of the health care entity, including a statement of the basis for the decision.

   d. Request for a Hearing: A Practitioner shall have 30 days following his or her receipt of a notice pursuant to Section 4.1c to file a written request for a hearing. Such request shall be delivered to the Administrator of the Center either in person or by certified or registered mail.

   e. Waiver by Failure to Request a Hearing: A Practitioner failing to request a hearing within the time and in the manner specified in Section 4.1d waives any right to such hearing and to any appellate review the Practitioner might otherwise have been entitled to.
f. **Effect of Waiver:** Waiver by failure to request a hearing shall constitute acceptance of that action, which shall thereupon become effective once approved by the Board of Managers and shall constitute waiver of all claims related to or arising out of the action.

**Section 4.2 – Pre-hearing Matters**

**a. Notice of Time and Place for Hearing:**

1. Upon receipt of a timely request for hearing, the Administrator shall deliver such request to the Medical Director and to the CRC.

2. As soon as reasonably practical after receipt of such request, the Medical Director or the CRC shall schedule and arrange for hearing, and the Administrator shall send the Practitioner special notice of the time, place, and date of the hearing. The hearing date shall not be less than 30 days or more than 90 days from the date of receipt of the request for hearing, unless mutually agreed by the Practitioner and the CRC.

**b. Statement of Issues and Events:**

1. The notice of hearing required by Section 4.2a shall contain a Notice of Charges consisting of a concise statement of the Practitioner’s alleged acts or omissions, a list by number of the specific or representative patient records in question and/or the other general reasons or subject matter forming the basis for the adverse recommendation or action which is the subject of the hearing, and a list of the witnesses expected to testify at the hearing on behalf of the CRC.

2. The Notice of Charges may be amended prior to the hearing; provided, however, that such amendment shall be provided to the Practitioner as soon as reasonably practical under the circumstances, and provided further that the Practitioner shall be entitled to a continuance if any such amendment substantially changes the scope of the hearing, or substantially affects the Practitioner’s ability to adequately prepare for the hearing. The presiding officer shall determine whether any such continuance is necessary.

**c. Witness Lists:**

1. Within fifteen days of receipt of the notice of hearing, the Practitioner shall forward to the CRC his/her list of witnesses (if any) who are expected to testify at the hearing. Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated. The parties shall notify each other as soon as they become aware of the possible participation of such additional witnesses.

**d. Appointment of Hearing Committee:**

1. A hearing occasioned by an adverse recommendation or action shall be conducted by a hearing committee appointed by the Administrator in consultation with the Medical Director and shall be held, as determined by the Administrator:

   (a) Before an arbitrator mutually acceptable to the Practitioner and the CRC;

   (b) Before a hearing officer who is appointed by the Center and who is not in direct economic competition with the Practitioner involved;
Before a hearing panel of individuals who are appointed by the Center and are not in direct economic competition with the Practitioner involved.

2. If the hearing is to be conducted by an arbitrator or hearing officer, references to the hearing committee shall be deemed to refer to the arbitrator or hearing officer.

3. The hearing committee members must be individuals who have not acted as an accuser, investigator, fact-finder, or initial decision maker in the same matter, and who shall gain no direct benefit from the outcome of the hearing. If feasible, and deemed advisable by the Administrator, the hearing committee may include an individual practicing the same specialty as the Practitioner.

a. **Pre-hearing Motions:** The parties shall be entitled to file pre-hearing motions as deemed necessary to give full effect to rights established by these Bylaws, and to resolve such procedural matters as the hearing officer determines may properly be resolved outside the presence of the full hearing committee. Such motions shall be in writing and shall specifically state the motion, all relevant factual information, and any supporting authority for the motion. The moving party shall deliver a copy of the motion to the opposing party, who shall have five working days to submit a written response to the hearing officer, with a copy to the moving party. The hearing officer shall determine whether to allow oral argument on any such motions. The hearing officers ruling shall be in writing and shall be provided to the parties promptly upon its rendering. All motions, responses, and rulings thereon shall be entered into the hearing record by the hearing officer.

Section 4.3 — Hearing Procedure

a. **Personal Appearance:** The Practitioner requesting the hearing shall be required to appear in person. A Practitioner failing to appear without good cause shall be deemed to have waived his/her rights in the same manner and with the same consequences as provided in Section 4.1e.

b. **Presiding Officer:** An attorney may be selected to serve as the presiding officer (or hearing officer); or, alternatively, if no hearing officer is selected, the Chair of the hearing committee shall be the presiding officer. (The terms "presiding officer" and "hearing officer" shall be deemed interchangeable throughout this Fair Hearing Plan.) The individual so serving shall gain no direct financial benefit from the outcome of the hearing, shall not act as a prosecuting officer or advocate. The presiding officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. The presiding officer shall be entitled to render rulings on pre-hearing matters (such as challenges to the selected committee members or hearing officer, requests for discovery, and pre-hearing motions; to determine the order of procedure during the hearing; to make all rulings on matters of procedure and the admissibility of evidence; and to take such discretionary action as deemed necessary under the circumstances to assure that the hearing is conducted in an efficient and expeditious manner.

c. **Examination by the Hearing Committee:** If the Practitioner requesting the hearing does not testify on his/her own behalf, the Practitioner may be called and examined as if under cross-examination. The hearing committee may also examine the witnesses.

d. **Procedure and Evidence:** The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence shall be admitted if it is the type of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule, which might make improper the admission of such evidence over objection in a civil or criminal action. The parties shall be entitled to submit, prior to or
during the hearing (or, in the discretion of the hearing officer, within 10 days of the close of the hearing) memoranda concerning any issue of law or fact. Such memoranda shall become a part of the hearing record.

e. **Burden of Proof:** The body whose adverse recommendation or action occasioned the hearing shall have the initial burden of going forward to present evidence in support thereof. The Practitioner shall thereafter have the burden of proof to support his/her challenge to the adverse recommendation or action, on the basis that the grounds there for lack any substantial factual basis or the conclusions drawn there from are arbitrary, unreasonable or capricious. Then, the body whose adverse recommendation or action occasioned the hearing shall have an opportunity to rebut the evidence, testimony, documentation and information presented by the affected Practitioner or his/her representative.

f. **Postponement:** Requests for postponement of a hearing shall be granted by the presiding officer only upon a showing of good cause and only if the request is made as soon as is reasonably practical.

g. **Presence of Hearing Committee Members and Vote:** A majority of the hearing committee must be present throughout the hearing and deliberations. If a committee member is absent from any part of the proceedings, that member shall not be permitted to participate in the deliberations or the decision unless and until he/she has read the entire transcript of the portion of the hearing from which he/she was absent.

h. **Recesses and Adjournment:** The hearing committee may recess the hearing and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon conclusion of its deliberations, the hearing shall be declared finally adjourned.

**Section 4.4 – Hearing Committee Report, Appellate Review and Further Action**

a. **Notice and Effect of Hearing Committee Findings and Recommendations:** The Administrator shall, not later than the end of the fifth (5th) working day after receipt of the Hearing Committee’s report and recommendations, notify the affected Practitioner of the findings and recommendations of the Hearing Committee by special notice, and shall also notify the Medical Director of same.

1. **Adverse Findings and Recommendation:** If the Hearing Committee’s findings and recommendations are adverse to the affected Practitioner, as determined by the Clinical Review Committee in consultation with Administration, the Notice sent by Administration to the affected Practitioner shall advise the affected Practitioner of his/her right to appellate review, the time period and requirements for submitting a request for appellate review, state that failure to request appellate review within the specified time period shall constitute waiver of the right to appellate review, and all other rights to which he/she may have otherwise been entitled under the Medical Staff Bylaws and other bylaws, policies, procedures, rules, regulations, guidelines, and requirements of the Center or its Medical Staff, and state that as soon as practicable after receipt of the request for appellate review, the affected Practitioner will be notified of the date, time and place of the appellate review.

2. **Favorable Findings and Recommendations of the Hearing Committee:** If the Hearing Committee’s findings and recommendations are favorable to the affected Practitioner, Administration shall promptly forward it, together with all supporting documentation, to the Board of Managers for final action. The Board of Managers shall take action thereon by adopting or rejecting the Hearing Committee’s
Recommendations in whole or in part, or by referring the matter back to the Healing Committee for further consideration. Any such referral back shall state the reasons therefore, set a time limit within which a subsequent recommendation should be made to the Board, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. As soon as practicable after receipt of such subsequent recommendation and any new evidence in the matter, the Board of Managers shall take final action. Administration shall promptly send the affected Practitioner special notice informing him of each action taken pursuant to this section of these Bylaws. Favorable action by the Board of Managers shall be effective as the final action, and the matter shall be considered finally closed. If the Board’s action is adverse to the affected Practitioner, as determined by the Board of Managers in consultation with Administration, the special notice the affected Practitioner of his right to request an appellate review as provided in these Bylaws.

b. Initiation and Prerequisites of Appellate Review:

1. **Request for Appellate Review:** Practitioner shall have ten (10) working days following his/her receipt of a notice pursuant to these Bylaws to file a written request for an appellate review by the Board Of Managers or a committee of the Board, comprised of not less than three members, appointed by the Board Of Managers. All references to the Board of Managers herein shall apply to a committee of the Board of Managers if one is appointed. A request for appellate review shall be delivered to Administration by hand delivery, or by certified or registered mail, return receipt requested, and may include a request for a copy of the hearing record, if same is not confidential or privileged or otherwise protected or prohibited by law, and all other material, favorable or unfavorable, if not previously forwarded, that was considered in the adverse action or result and is not confidential or privileged or otherwise protected or prohibited by law.

2. **Notice of Time and Place for Appellate Review:** Administration shall deliver the request for appellate review to the Board. As soon as practicable, the Board Of Managers shall schedule and arrange for an appellate review which shall not be less than ten (10) working days after the date of receipt of the appellate review request without the written consent of the affected Practitioner and shall be scheduled for a time as soon as practicable after receipt of such request for appellate review. Not later than the end of the fifth working day prior to the appellate review, Administration shall send the Practitioner special notice of the time, place and date of the appellate review. The time for the appellate review may be extended for good cause by the Board, within its sole discretion, and if the request therefore is made as soon as practicable.

c. Appellate Review Procedure:

1. **Nature of Proceedings:** The proceedings shall be in the nature of an appellate review of the procedures employed and shall be based upon the record of the hearing before the Hearing Committee, the Hearing Committee’s report, and all subsequent results and actions thereon. The appellate review shall also consider the written statements, if any, submitted pursuant these Bylaws and such other materials as may be presented and accepted under these Bylaws.

2. **Written Statement:** The Practitioner seeking appellate review must submit a written statement detailing the findings of fact, conclusions and procedural matters with which he/she disagrees, and his/her reasons for such disagreement by hand delivering same or by certified or registered mail, return receipt requested, to Administration. Administration shall forward a copy of the Practitioner’s written statement to the body whose adverse action or recommendation occasioned the
appellate review and such body may file a written statement in response thereto. The written statement may cover any matters raised at any step in the hearing process and legal counsel may assist in its preparation. The Practitioner's statement shall be submitted to the Board Of Managers through Administration at least fifteen (15) days prior to the scheduled date of the appellate review and the written statement of the body whose adverse action or recommendation occasioned the appellate review in response thereto, if any, shall be submitted to Administration by hand delivery or certified or registered mail, return receipt requested, at least five (5) days prior to the appellate review. A copy of the written statement in response to the affected Practitioner's statement, if any, shall be sent by hand delivering same or by certified or registered mail, return receipt requested, to the affected Practitioner as soon as practicable prior to the scheduled date of the appellate review but in any event Administration shall ensure that the affected Practitioner has access to the written statement in response to the affected Practitioner's statement not later than twenty-four (24) hours prior to the scheduled date and time of the appellate review.

3. **Oral Statement:** The Board of Managers will allow the parties or their representatives to personally appear and make oral statements in favor of their positions. Any party or representative so appearing shall be required to answer questions put to him by any member of the Board.

4. **Consideration of New or Additional Matters:** New or additional matters or evidence not raised or presented during the original hearing which the Board of Managers deems may be significant to the Hearing Committee's report and recommendation may be referred back to the Hearing Committee for reconsideration of its recommendations in light of the new or additional matters or evidence. New or additional matters or evidence not raised or presented at the original hearing may only be introduced upon good cause shown, as determined by the Board Of Managers as to why such was not introduced at the original hearing. The other party shall be given an opportunity to respond to such new or additional matters or evidence.

5. **Presence of Members and Vote:** A quorum of the Board of Managers must be present throughout the review and deliberations. If a member of the Board of Managers is absent for any significant time period during the proceedings, as determined by the Board, he/she shall not be permitted to participate in the decision.

6. **Final Action:** The Board's decision shall be forwarded to Administration, who shall notify the Board of Managers of the decision and provide special notice of the decision to the affected Practitioner not later than the end of the fifty (50) working day after the date of the Board's action in the matter. The Board's action shall be final action not subject to further hearing or appellate review.

**Section 4.5 – General Provisions**

a. **Hearing Officer Appointment and Duties:** The use of a hearing officer to preside at an evidentiary hearing is optional. The Administrator, in consultation with the Medical Director, shall determine the use and appointment of such.

b. **Number of Hearings:** Notwithstanding any other provision of these Bylaws, no Practitioner shall be entitled as a right to more than one evidentiary hearing with respect to an adverse recommendation or action.

c. **Release:** By requesting a hearing or appellate review under this Fair Hearing Plan, a Practitioner agrees to be bound by the provisions of these Bylaws relating to immunity from suit and from liability in all matters relating thereto.
d. **Required Reports:** The State Professional Licensing Board and the National Practitioner Data Bank will be notified of adverse hearing results in accordance with any applicable State and Federal laws and regulations.

**Section 4.6 – Grievance Process**

Nothing contained in these Bylaws shall be interpreted to entitle an AHP to the hearing and appeal rights set forth in these Bylaws, unless otherwise required by law. However, an AHP may challenge any action by filing a written grievance, within fifteen (15) days of the adverse recommendation or action, with the Administrator. Upon receipt of the grievance, the Administrator shall notify the Medical Director, initiate an investigation and afford the AHP an opportunity for an interview. A representative of the CRC or its designee may appoint a committee to conduct the interview. A representative of the CRC and Administrator, or their designees, shall participate in any such interview. The interview shall not constitute a “hearing” as established in these Bylaws, and shall not be conducted according to the procedural rules applicable with respect to such hearings. Before the interview, the AHP shall be informed of the general nature of the circumstances-giving rise to the action. The affected AHP may present relevant information at the interview. The final decision shall be made by the Board of Managers.

**ARTICLE V – MEDICAL STAFF COMMITTEES**

**Section 5.1 – Ad Hoc Committees**

The CRC may authorize ad hoc committees to accomplish specific, temporary functions.

**Section 5.2 – Appointment**

Membership on standing or ad hoc committees shall be appointed by the Medical Director and shall serve at his/her discretion unless otherwise specified by these Bylaws. Administrative staff members shall serve in a nonvoting capacity.

**Section 5.3 – Reports**

Each committee established by the Bylaws shall report on its activities to the Board of Managers on a routine basis. It is the duty of the committee chair to sign necessary correspondence and review and initial committee meeting minutes prior to distribution.

**Section 5.4 – Clinical Review Committee**

a. **Composition:** The Clinical Review Committee shall be a permanently organized committee and shall consist of the medical director and representation of the various specialties, whom are selected by the Center medical staff. The Administrator, or designee, may also participate in the CRC and serve as a liaison between the CRC and Board as a non-voting member.

b. **Meetings:** The CRC will meet at least quarterly on a regular basis but may occasionally meet more often, if required. Members of the CRC will serve for two years unless removed by the medical staff and may be re-appointed.

c. **Responsibilities:** The responsibilities of the CRC are as follows:

1. To represent and act on behalf of the Medical Staff subject to such limitations as may be imposed by these Bylaws.
2. To receive and act upon committee reports and make necessary recommendations to the Board of Managers.

3. To implement policies, both clinical and administrative, of the Medical Staff.

4. To review applications for initial appointment and reappointment of Medical Staff membership & AHP's and delineation of or changes to clinical privileges.

5. To review all information available regarding the performance and clinical competence of Medical Staff members & AHP's using the results of such reviews to make recommendations for reappointments, renewal and changes in clinical privileges.

6. To take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of members of the Medical Staff, and AHPs.

7. Insofar as relates to the Medical Staff, to monitor and assure compliance with applicable accreditation standards.

8. To promulgate such rules and regulations, or policies and procedures as deemed necessary and appropriate for the effective provision of patient care and/or operation of the Medical Staff.

9. To oversee the performance of the Patient Care Committee and any ad hoc committees.

10. Oversight of all quality improvement activities pertinent to this facility including but not limited to; patients, the Medical Staff, Allied Health Practitioners, facility employees, contracted services, etc.

d. Minutes: A permanent record will be kept of each meeting and these minutes will be submitted to the Board of Managers.

Section 5.5 – Patient Care Committee

a. Composition: The Patient Care Committee (PCC) may be composed of one or more representatives from Center departments, such as: Administration, Business Office, Pre-op and Admitting, OR nursing staff, scrub technician, CRNA, Recovery Room nursing staff, Medical Director, etc. Members (other than ex-officio members) will serve for one year and may be re-appointed.

b. Meetings: The PCC will generally meet monthly, but may skip meetings as deemed appropriate (e.g., during holiday or vacation seasons) and subject to call of such special meetings as may be necessary to review particular problems or issues that may arise during the period between scheduled meetings.

c. Responsibilities: The purpose of the PCC is to monitor important aspects of care and to encourage communication about Center operations, which will provide maximum opportunities to implement continuous quality improvement and to aid in quality assurance. The committee will review at least the following at each meeting:

1. All incident/occurrence reports related to patient, visitor, employee and medical staff member safety.

2. All patient evaluation cards and surveys.
3. All direct Center admissions and transfers.

4. All complication data generated by chart review.

5. Medical chart audit studies (at least one per quarter).

d. Minutes: A permanent record will be kept of each meeting and these minutes will be submitted to the Clinical Review Committee.

ARTICLE VI – CONFIDENTIALITY, IMMUNITY, AND RELEASES

Section 6.1 – Authorization and Conditions

By applying for, or exercising clinical privileges within the Center, an applicant:

a. Authorizes representatives of the Center and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's and subsequent Medical Staff member's professional ability and qualifications;

b. Authorizes persons and organizations to provide information concerning such Practitioner to the Medical Staff and waives any and all claims arising there from;

c. Agrees to be bound by the provisions of this Article;

d. Acknowledges that the provisions of this Article are express conditions to an application for Medical Staff Membership, the continuation of such membership, and to the exercise of clinical privileges at the Center.

Section 6.2 – Confidentiality of Information

a. General: Medical Staff and Committee minutes, files, applications and records, including information regarding any member or applicant to the Medical Staff, shall be confidential to the fullest extent possible and practical. Dissemination of such information and records shall be made where authorized by law, pursuant to adopted policies of the Medical Staff in its efforts to monitor the quality of care, or where no officially adopted policy exists, with the approval of the CRC following written request. Peer review information is confidential and as such is protected under State and Federal regulations.

b. Breach of Confidentiality: Inasmuch as effective peer review and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussion or deliberations of Medical Staff committees, except in conjunction with necessary communication within the Center or with other health facilities, professional review organizations, professional societies, or licensing authorities, is outside appropriate standards of conduct for the Medical Staff and may be deemed disruptive to the operations of the Center. If it is determined that such a breach has occurred, the CRC may undertake such corrective action, as it deems appropriate in accordance with Sections 3.22 and 3.23 of these Bylaws.

Section 6.3 – Immunity from Liability for Suit and Damages

a. For Action Taken: Each representative of the Medical Staff and the Center shall be immune, to the fullest extent permitted by law, from liability for suit and for damages to an applicant or member for damages or other relief for any action taken, statements, or recommendations

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made within the scope of his/her duties as a representative of the Medical Staff or the Center.

b. For Providing Information: Each representative of the Medical Staff or the Center and all third parties shall be immune, to the fullest extent permitted by law, from liability for suit and for damages to an applicant or member for damages or other relief by reason of providing information to a representative of the Medical Staff or the Center concerning such person who is, or does, exercise clinical privileges or provide services at the Center.

Section 6.4 – Activities and Information Covered

a. The confidentiality and immunity provided by this Article shall apply to all acts, communication, reports, recommendations or disclosures performed or made in connection with this or any other health facility's or organization's activities concerning, but not limited to:

1. Application for appointment, reappointment, or clinical privileges;
2. Corrective action;
3. Fair Hearing and Appellate Review;
4. Utilization or quality assurance review;
5. Other Committee or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and
6. Peer review organizations, State Professional Licensing Board, National Practitioner Data Bank and similar reports as required by law.

Section 6.5 – Releases

Each applicant or member shall, upon request of the Medical Director, Medical Staff or the Administrator, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite of the effectiveness of this Article.

ARTICLE VII – APPROVAL AND AMENDMENT OF BYLAWS

Section 7.1 – Adoption or Amendment of Bylaws

a. Required Review: Bylaws require review and comment by the Medical Staff and CRC.

b. Board of Managers Approval: Bylaws adoption and amendments shall not be effective until and unless approved by the Board Of Managers.

ARTICLE VIII - GENERAL PROVISIONS

Section 8.1 – Adoption of Medical Staff Rules and Regulations

The Medical Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these Bylaws. The rules and regulations shall relate to the proper conduct of Medical Staff organizational activities and will embody the specific standards and level of practice that are required of each Medical Staff Member and other designated individuals who exercise Clinical Privileges or provide designated patient care services in the Facility. Such rules and regulations may be amended or repealed at any regular meeting of the Medical Staff at
which a quorum is present, and without previous notice.

Section 8.2 – Implementation of Rules and Regulations

The Medical Staff shall formulate and implement rules and regulations, which will become effective upon recommendation of the CRC and final approval of the Board of Managers. Medical Staff rules and regulations shall be consistent with these Bylaws and with established Facility policies.

Section 8.3 – Relationship to Bylaws

In the event there is a discrepancy between the Bylaws and any rules and regulations, the Bylaws shall supersede the rules and regulations.

Section 8.4 – Disputes with the Board of Managers

In the event of a dispute between the Medical Staff and the Board of Managers, the CRC and Board of Managers shall meet and confer in good faith to try to resolve the dispute. If both the CRC and Board of Managers agree, a neutral mediator acceptable to both the CRC and Board of Managers may be engaged to further assist in dispute resolution. If the parties are unable to resolve the dispute, the Board of Managers shall make its final determination, giving great weight to the actions and recommendations of the CRC. Further, the Board of Managers determination shall not be arbitrary or capricious, and shall be in keeping with its legal responsibilities to act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of the Facility.

Amended and Restated Medical Staff Bylaws of The Surgery Center at Lutheran, November 2011

These Bylaws were approved and ratified as follows:

Clinical Review Committee

[Signature]

Date 11/2/11

Board of Managers

[Signature]

Date 11/2/11