



**PARKVIEW**  
**HEALTH**

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**PARKVIEW ORTHO CENTER, LLC  
D/B/A PARKVIEW SURGERY ONE**

# **MEDICAL STAFF BYLAWS**

**Governance and Credentialing Manual**

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## **DEFINITIONS**

The following definitions, unless otherwise expressly indicated, apply throughout the Medical Staff Bylaws. The Medical Staff Bylaws include: (1) the Governance and Credentialing Manual, and (2) the Corrective Action and Fair Hearing Manual. The use of capitalization when defining terms is intended for convenience purposes only and shall not affect the meaning or interpretation of such terms.

**“Administration”** or **“ASC Administration”** refers to and includes the ASC’s Chief Operating Officer, the COO’s senior management team (if any), and each of their authorized designees.

**“Administrative Action”** means any determination, recommendation or action taken by or on behalf of the ASC’s Board of Managers or Medical Staff, or their respective designees, that are not professional review actions, but instead, are made or taken without a prior hearing for reasons related to objective administrative circumstances, as set forth in these Medical Staff Bylaws.

**“Advanced Practice Professional”** or **“APP”** means any individually licensed or certified health care provider (excluding a Physician or Podiatrist) who: (a) has an independent or dependent scope of practice, (b) is authorized by the Governing Board to exercise specified Clinical Privileges within the ASC in a manner that is consistent with the provider’s scope practice, and (c) is therefore credentialed through the Medical Staff credentialing process. A current list of APPs, which may be updated from time to time, is attached hereto and incorporated herein as Appendix A.

**“Allied Health Practitioner”** or **“AHP”** means any individually licensed or certified health care provider (excluding a Physicians, Podiatrists, or APPs) who: (a) has a strictly dependent scope of practice, (b) is credentialed through the ASC’s Human Resources Department or other designated ASC office, and (c) is not eligible to receive or exercise specified Clinical Privileges within the ASC. Dependent Practitioners include, by way of example, registered nurses, counselors, non-physician surgical assistants, and other such dependent practitioners.

**“Ambulatory Surgery Center”** or **“ASC”** means the ambulatory surgery center known as Parkview Ortho Center, LLC, d/b/a Parkview Surgery ONE (“PSO”) which is jointly owned and operated by Parkview Health and Orthopaedics Northeast, P.C., including all locations subject to its state-issued facility license.

**“Applicant”** means any Physician, Podiatrist or other eligible Non-Physician Practitioner applying for initial appointment to the Medical Staff and/or for Clinical Privileges at the ASC, as applicable.

**“Bylaws, Policies, and Procedures”** shall refer to and include all applicable System, ASC, and Medical Staff Bylaws, Rules, Regulations, and Policies.

**“Chief Operating Officer”** or **“COO”** means the individual appointed by the Governing Board to act on its behalf in the overall management of the ASC.

**“Clinical Privileges”** means the permission granted to a Practitioner by the Governing Board to render specific patient care services within the Practitioner’s lawful scope of practice to patients at the ASC, and permission to efficiently use ASC resources necessary to exercise granted Clinical Privileges.

**“Days”** unless otherwise indicated, means “calendar days” (i.e. including Saturday, Sunday, and legal holidays) unless the due date falls on a Saturday, Sunday or federally recognized legal holiday, in which case the due date shall be the first (1st) day immediately following the day that is not a Saturday, Sunday, or such legal holiday.

**“Direct Economic Competition”** means those situations or circumstances when two individuals share the same Clinical Privileges at the ASC and/or when their health care practices substantially overlap such that the individuals compete to provide the same type of health care services to the same population of patients.

**“Ex Officio”** means service as a member of a committee or other designated body by virtue of an office or position held, such service being without voting rights unless otherwise specified.

**“Focused Professional Practice Evaluation”** or **“FPPE”** or **“Focused Quality Review”** refers to the Peer Review evaluation, for privilege-specific competency, of Applicants seeking Clinical Privileges at the ASC and of Practitioners who have requested to receive new or additional Clinical Privileges; and also refers to the Peer Review evaluation of Practitioners when specific performance-related concerns implicating patient safety and/or quality of care are identified.

**“Good Standing”** means a Practitioner who, during the current term of appointment to the Medical Staff and/or term of Clinical Privileges, continues to maintain all qualifications for Medical Staff Membership, Clinical Privileges, and assigned category, as applicable, and is in compliance with all responsibilities attendant to Medical Staff Membership and Clinical Privileges, as applicable.

**“Governing Board”** or **“Board”** means the Board of Managers of the ASC.

**“Law”** shall refer to all applicable Federal and State laws, rules, and regulations, as well as all pertinent Accreditation Standards.

**“Medical Director”** means the individual appointed by the Governing Body of the ASC to serve as the liaison between the Medical Staff and the Governing Body and who, in so doing, provides oversight over the Medical Staff’s compliance with the Bylaws, Policies, and Procedures, and overall direction to the Medical Staff in the continuing performance of its services.

**“Medical Staff Executive Committee”** or **“MSEC”** means the executive committee of the Medical Staff, which shall have a composition and shall undertake such functions as set forth in the Medical Staff Bylaws.

**“Medical Staff”** means all Physicians and Podiatrists who have been granted Membership on the Medical Staff by the Governing Board.

**“Medical Staff Bylaws”** or **“Bylaws”** means the Medical Staff Bylaws of the ASC’s Medical Staff, which include both the Governance and Credentialing Manual and the Corrective Action and Fair Hearing Manual.

**“Medical Staff President”** (or **“President of the Medical Staff”** or **“Chief of Staff”**) means the principal elected officer of the organized Medical Staff.

**“Member”** means any Physician or Podiatrist who has been granted Membership on the Medical Staff by the Governing Board.

**“Membership”** means the participation as a Member of the Medical Staff, and which therefore includes, and expressly subject to, all attendant requirements, rights, and obligations.

**“Ongoing Professional Practice Evaluation”** or **“OPPE”** or **“Ongoing Review”** means the systematic and ongoing Peer Review process used to evaluate and confirm the current competency of those Practitioners with Clinical Privileges at the ASC.

**“Peer Review”** refers to any and all activities and conduct of Peer Review Committees ultimately intended, either directly or indirectly, to further the quality of patient care provided at the ASC. Peer Review, as defined by Indiana's Peer Review Statute, includes the evaluation of qualifications of health care providers, patient care rendered by health care providers, and complaints or concerns regarding the professional conduct or competency of health care providers, which affects or could affect adversely the health or welfare of a patient or patients. Peer Review at the ASC includes, but is not necessarily limited to, the credentialing process, the corrective action and fair hearing process, quality assurance and performance improvement activities, utilization review activities, and all other review processes that are consistent with Peer Review in Indiana.

**“Peer Review Committee”** means a committee of the Medical Staff or ASC that is formed in a manner consistent with Indiana and Federal law and that is responsible, in full or in part, for engaging in Peer Review. By way of example, Peer Review Committees at the ASC include the Governing Board, the Medical Staff (as a whole), the MSEC, and any other committee of the Medical Staff and/or ASC that is tasked, in full or in part, with engaging in Peer Review. Peer Review Committees include not only those serving as members of the committees, but also their employees, designees, representatives, agents, attorneys, consultants, investigators, experts, assistants, clerks, staff and any other persons or organizations, whether internal or external, who assist the committee in performing its Peer Review functions. All reports, studies, analyses, documents, materials, determinations, deliberations, recommendations, and other similar communications that are authorized, requested or reviewed by a Peer Review Committee or persons acting on behalf of a Peer Review Committee shall be treated as strictly confidential and not subject to discovery nor admissible as evidence consistent with, and to the full extent permitted by, those protections afforded under applicable Indiana law. If a Peer Review Committee or its designee deems appropriate, assistance may be obtained, in an appropriate manner, from other Peer Review Committees, other committees, individuals or organizations inside or outside the ASC. Each Peer Review Committee of the ASC and Medical Staff hereby claims all privileges, protections, and immunities available to such committee.

**“Physician”** means a duly licensed allopathic or osteopathic Physician.

**“Podiatrist”** means a duly licensed Podiatrist.

**“Practitioner”** means any Physician, Podiatrist, or APP who has been granted Medical Staff Membership and/or Clinical Privileges at the ASC, as applicable.

**“Professional Review Action”** means an action or recommendation of a Peer Review Committee, taken in the course of a professional review activity, based upon a Practitioner's competence or professional conduct (which conduct affects or could adversely affect the health or welfare of a patient or patients), and which adversely affects (or may adversely affect) the Practitioner's Medical Staff Membership and/or Clinical Privileges. Such term includes a formal decision of a Peer Review Committee not to take an action or make a recommendation described in the previous sentence.

**“Special Notice”** means any notice required to be given under the Medical Staff Bylaws, unless otherwise stated, that is designated as a “Special Notice.” Such notice shall be in writing and shall be deemed given when personally delivered, or sent by prepaid United States certified mail with return receipt requested, traceable courier services, confirmed email communication, or confirmed facsimile. All Special Notices shall be considered received on the date actually received if given by personal delivery or traceable courier service, or on the date shown as received on the certified mail receipt, email confirmation, or fax confirmation sheet if given by such method. A refusal to accept delivery of service shall constitute effective delivery as of the date of any such refusal.

**“System”** means Parkview Health, including the ASC and all other legal entities wholly owned and/or operated by Parkview Health.

Words used in the Medical Staff Bylaws shall be read interchangeably as the masculine or feminine gender and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of the Bylaws.

## **ARTICLE I**

### **PURPOSES OF THE MEDICAL STAFF**

The purposes of the Medical Staff shall be to:

- (a) Establish, maintain, amend, and enforce Medical Staff Bylaws for the self-governance of the Medical Staff, which shall be reviewed periodically (and revised as necessary subject to final review and approval by the Governing Board);
- (b) Provide oversight for the quality of patient care, treatment, and services provided by Practitioners at the ASC;
- (c) Provide an environment where patients admitted to or treated in the ASC receive appropriate, timely, quality medical care without discrimination on the basis of race, national origin, handicap, religion, color, creed, sex, age, financial status or other legally protected status;
- (d) Promote an acceptable level of professional performance of all Practitioners authorized to practice in the ASC by the Governing Board, through the appropriate evaluation of Practitioners applying or reapplying for Medical Staff Membership and/or Clinical Privileges, as applicable, through delineating the scope of Clinical Privileges that will be granted to Practitioners, and through the ongoing review and evaluation of each Practitioner's performance in the ASC;
- (e) Provide a means whereby issues concerning the Medical Staff and the ASC may be discussed among the Medical Staff and Governing Board, through their appointed members and/or designees;
- (f) Carry out Peer Review activities, both alone and in conjunction with ASC Administration, as agents of the Governing Board, in making recommendations for the credentialing and recredentialing of Applicants and Practitioners, in setting standards for and reviewing the efficient and effective use of ASC resources, in investigating professional conduct and/or clinical concerns, and in carrying out other Peer Review functions in the furtherance of quality of care;
- (g) Provide an appropriate educational setting that will lead to continuous advancement in professional knowledge and skill;
- (h) Establish policy(s) and/or procedure(s) that will ensure any needs or concerns expressed by Members of the Medical Staff, regardless of practice or location, are given due consideration; and
- (i) Establish, maintain, and enforce rules, regulations, policies, and procedures to ensure the Medical Staff functions and renders professional services in a manner that is compliant with applicable Law.

## **ARTICLE II**

### **ELIGIBILITY FOR MEDICAL STAFF MEMBERSHIP AND/OR CLINICAL PRIVILEGES**

#### **2.1. Nature of Medical Staff Membership and Clinical Privileges**

- (a) Membership on the Medical Staff is a privilege, which shall be extended only to those Physicians and Podiatrists who have demonstrated a high level of professional competence and have met, and continue to meet, the qualifications, standards and requirements set forth in the Medical Staff Bylaws. No Physician, Podiatrist, or APP shall provide services to patients in the ASC unless he or she has been appropriately granted Clinical Privileges to do so.
- (b) A doctor of medicine (MD) or osteopathy (DO) shall be responsible for the care of each patient with respect to any medical condition that is not within the scope of practice and Clinical Privileges of a non-physician. Neither the ASC nor the Medical Staff shall discriminate on the basis of race, national origin, handicap, religion, color, creed, sex, age, financial status or other legally protected status that does not affect a Practitioner's ability to safely and reasonably provide care to patients with or without reasonable accommodation.
- (c) Any Practitioner who is engaged, individually or through a legal entity, by the ASC as an independent contractor or employed Practitioner to provide specified clinical services at the ASC must possess Medical Staff Membership and Clinical Privileges, as applicable, as recommended by the Medical Staff and granted by the Governing Board. The Membership and/or Clinical Privileges of such Practitioners may be subject to Administrative termination to the extent such termination is made a part of the applicable employment or independent contractor agreement.

#### **2.2. Qualifications for Medical Staff Membership and Clinical Privileges**

##### **2.2.1. General Standards**

Only those Physicians, Podiatrists, and APPs who can document appropriate licensure, certification, background, education, training, experience, professional competence, health status, reputation, character, judgment, and ability to work with others, as well as adherence to the ethics of their professions and to the Bylaws, Policies, and Procedures shall be eligible for Medical Staff Membership and/or the granting of Clinical Privileges, as applicable.

### 2.2.2. Basic Qualifications

As an initial matter, given the ASC's affiliation with Orthopaedics Northeast, P.C., unless the Governing Board elects to make an exception in order to address a particular clinical service need, only individuals who are employed or contracted by Orthopaedics Northeast, P.C., shall be eligible to apply for Medical Staff Membership and/or Clinical Privileges at the ASC. Any individual who requests that an exception be made by the Governing Board, as set forth above, must make such request by and through the pre-application process set forth in Section 4.1, below. The Governing Board's grant or denial of such exception shall constitute an Administrative Action.

In addition to above, only those Applicants and Practitioners who can continuously demonstrate or provide evidence of the following qualifications to the satisfaction of the MSEC and Governing Board will be eligible for Medical Staff Membership and/or the granting of Clinical Privileges, as applicable:

- (a) Current and valid, non-probationary and unrestricted (meaning not subject to any sanction) Indiana license applicable to his or her profession;
- (b) Current, valid, and unrestricted Drug Enforcement Administration ("DEA") registration (with appropriate Indiana registration) and Indiana Controlled Substances registration, unless such registrations, in the discretion of the MSEC, are not required by, or attendant to, the Clinical Privileges sought or maintained by a Practitioner;
- (c) Eligibility to participate in federal and Indiana governmental health care programs, including but not limited to Medicare and Medicaid;
- (d) Absence of: (i) any felony criminal conviction (or pending charge or indictment if an Applicant), or (ii) any misdemeanor criminal conviction (or pending charge of a new Applicant) that would violate the pertinent requirements for participation in the Medicare program or Indiana Medicaid Program; or of which the Medical Staff Executive Committee otherwise deems unable to make an exception;
- (e) Professional liability insurance in such amount and of such a type so as to qualify as to be a "Qualified Provider" pursuant to Indiana's Medical Malpractice Act and participate in the Indiana Patient's Compensation Fund (or, notwithstanding the foregoing, if the Governing Board permits an exception to the foregoing requirement for good cause, maintain professional liability insurance in the coverage, scope, amounts and/or limits that have been established by the Governing Board for such Practitioner(s));
- (f) Acceptable character, competence, training, experience, background, and judgment;
- (g) Compliance with all applicable guidelines and opinions set forth in the Code of Medical Ethics of the American Medical Association, the Code of Ethics of

the American Osteopathic Association, the Principles of Ethics of the American Podiatric Association and all other applicable ethical guidelines of the Applicant's or Practitioner's licensing body;

- (h) Evidence of an active clinical practice and satisfactory clinical performance within the preceding twenty-four (24) months in the area in which Clinical Privileges are sought (whether in professional practice and/or as part of residency, as applicable), which is adequate to meet the ASC's current criteria for clinical competence;
- (i) Acceptable professional liability case frequency, judgment or settlement history;
- (j) Subject to applicable Law, physical and mental ability and health status necessary to perform the obligations of Medical Staff Membership and the requested Clinical Privileges, as applicable, to the satisfaction of the ASC and Medical Staff;
- (k) Appropriate written and verbal communication skills;
- (l) Willingness and ability to properly discharge the responsibilities established by the ASC, Governing Board and Medical Staff; and
- (m) Board eligibility or certification, as applicable, as required by Section 2.2.3 of these Bylaws;
- (n) Absence of any prior adverse clinical privileging actions, including but not limited to restrictions, suspensions, and/or revocations of medical staff membership and clinical privileges at the ASC or other hospitals, ambulatory surgery centers, or other health care facilities, unless the Governing Board, following recommendation from the MSEC, determines (in its sole discretion) to make an exception; any refusal by the MSEC or Governing Board to make such an exception shall constitute an Administrative Action;
- (o) Absence of any prior employment termination by, or resignation from, a System affiliate that resulted from or was related to, in full or in part, concerns by the employer involving the Applicant's or Practitioner's professional competency and/or professional conduct (irrespective of whether the employment resulted in a resignation or separation agreement, or of a termination, whether such termination was designated as "for cause" or "without cause"), unless the Governing Board, following recommendation from the MSEC, determines (in its sole discretion) to make an exception; any refusal by the MSEC or Governing Board to make such an exception shall constitute an Administrative Action;
- (p) Absence of any exclusive professional services agreement, discontinuance, or closure that would preclude Medical Staff Membership and/or Clinical Privileges, as applicable, as set forth Article XII, below; and

- (q) If applying to receive, or if otherwise maintaining, Clinical Privileges to perform surgery at the ASC, the Applicant or Practitioner, as applicable, must continuously maintain admitting privileges at one or more hospitals in the same county as the ASC or in an adjacent Indiana county;

No Applicant or Practitioner shall be entitled to Membership on the Medical Staff and/or Clinical Privileges in the ASC, as applicable, merely by virtue of: (a) licensure in Indiana or in any other state; (b) certification, fellowship, or membership in any professional organization, specialty body or society; or (c) employment by any System affiliate or other entity, or (d) by virtue of holding similar Clinical Privileges at any other health care organization.

### **2.2.3. Board Certification**

- (a) All Physician, Podiatrist, Nurse Practitioners, and Physician Assistant Applicants for Medical Staff Membership and/or Clinical privileges, as applicable, must be board certified in a specialty that is reasonably related, in the discretion of the MSEC, to the Clinical Privileges they seek.
- (b) As an exception to subsection (a), above, Applicants to the Medical Staff may be board eligible when they initially apply for Medical Staff Membership and/or Clinical Privileges, as applicable, in a specialty that is reasonably related, in the discretion of the MSEC, to the Clinical Privileges they seek. Such Applicants, however, must become board certified in such specialty as soon as reasonably possible, but in all instances, within the time period required by the Applicant's applicable specialty board for certification following eligibility. If the specialty board does not identify a maximum period of time for certification following eligibility, then the Applicant is hereby required to achieve certification within five (5) years of initial eligibility. A failure to timely achieve board certification, as required by this subsection, shall result in the immediate and automatic termination of Medical Staff Membership and/or Clinical Privileges, as applicable. Such termination shall constitute an Administrative Action.
- (c) As an additional exception to subsection (a), above, if an Applicant has completed his/her residency or fellowship training in the twelve (12) month period prior to applying to the Medical Staff, and the pertinent specialty board expressly requires a defined period of clinical practice prior to board eligibility, then such Applicants may apply for Medical Staff Membership and/or Clinical Privileges, as applicable, but must then achieve board eligibility within two (2) years of initial appointment. Thereafter, the Applicant must achieve board certification within the time requirements set forth in the preceding subsection (b). A failure to timely achieve board eligibility or certification, as required by this subsection, shall result in the immediate and automatic termination of Medical Staff Membership and/or Clinical Privileges, as applicable. Such termination shall constitute an Administrative Action.

- (d) Specialty boards/certification must be acceptable, as follows:
- (i) With respect to Physicians, acceptable specialty boards include those boards recognized by the American Board of Medical Specialties and the American Osteopathic Association, or any other specialty board approved by the Governing Board upon recommendation of the MSEC. Board certification must be in a specialty that is reasonably related to the Clinical Privileges sought by or granted to the Applicant or Member.
  - (ii) With respect to Podiatrists, acceptable specialty boards include those boards recognized by the American Boards of Podiatric Surgery and Podiatric Medicine, the American Board of Multiple Specialties in Podiatry, or any other specialty board approved by the Governing Board upon recommendation of the MSEC. Board certification must be in a specialty that is reasonably related to the Clinical Privileges sought by or granted to the Applicant or Member.
  - (iii) With respect to Nurse Practitioners, certification must be by/through: the American Nurses Credentialing Center, National Certification Corporation, National Certification Board of Pediatric Nurse Practitioners and Nurses, Oncology Nursing Certification Corporation, American Academy of Nurse Practitioners, or any other certifying body approved by the Governing Board upon recommendation of the MSEC.
  - (iv) With respect to Physician Assistants, certification must be by/through the National Commission on Certification of Physician Assistants or any other certifying body approved by the Governing Board upon recommendation of the MSEC.
- (e) Physicians and Podiatrists who (i) were initially appointed to the Medical Staff and/or who maintained Clinical Privileges, as applicable, as of January 1, 2013 (the “Grandfather Date”), who were not board certified at the time of such appointment, and who have maintained continuous and uninterrupted Medical Staff Membership and/or Clinical Privileges, as applicable, since this date, or (ii) who were initially appointed to the Medical Staff at a time when no specialty board existed that was reasonably related, in the discretion of the MSEC, to the Clinical Privileges they sought, and who have maintained continuous and uninterrupted Medical Staff Membership and/or Clinical Privileges, as applicable, since this date shall not be required to become board certified (or maintain board certification) as a condition of continued Medical Staff Membership and/or Clinical Privileges, as applicable, provided that these Practitioners otherwise meet the established competency requirements and other relevant criteria established by the Medical Staff and Governing Board. All other Physicians and Podiatrists who are Applicants or Members must meet the board certification requirements set forth in this Section 2.2.3.

- (f) Except for those Practitioners who were appointed to the Medical Staff and/or maintained Clinical Privileges, as applicable, as of the Grandfather Date and who have maintained continuous and uninterrupted Medical Staff Membership and/or Clinical Privileges, as applicable, since this date, all Applicants and Practitioners must not only satisfy the Board Certification requirement in this Section 2.2.3, but must also remain board certified as an ongoing condition of Medical Staff Membership and/or Clinical Privileges, as applicable, unless an express exception is made as provided herein.
- (g) In the event a Physician, Podiatrist, Nurse Practitioner, or Physician Assistant applies for new or additional Clinical Privileges that (in the discretion of the MSEC or Governing Board) relate to a clinical specialty that is different than the Practitioner's current specialty, or are otherwise inconsistent with or beyond the scope of the Practitioner's current clinical practice, then the Practitioner shall be required to satisfy the board certification requirements set forth in this Section 2.2.3.
- (h) In exceptional circumstances, the MSEC may recommend, and the Governing Board may approve, a temporary or permanent waiver of the Board eligibility and/or Board Certification requirements required by this Section 2.2.3. Any recommendation in this regard should be supported by particular documentation and/or other information, which demonstrates good cause for making an exception, and which includes sufficient evidence of training, education, competence, experience, and ability to safely perform the Clinical Privileges requested. The determination to make an exception pursuant to this subsection (h) shall relate only to the particular Clinical Privileges sought and granted (or their future equivalent). Such an exception shall not constitute an exception as to any new or additional Clinical Privileges that are thereafter sought.
- (i) All determinations made by the MSEC and Governing Board with respect to application or waiver of the board certification requirements, as set forth in and contemplated this Section 2.2.3, shall constitute Administrative Actions, and as such, shall not entitle the Applicant or Practitioner subject of the request to any fair hearing or other rights to due process.

### **2.3. Responsibilities of Medical Staff**

As initial and ongoing conditions for appointment/reappointment to the Medical Staff and for Clinical Privileges at the ASC, as applicable, each Applicant and Practitioner shall:

- (a) Provide appropriate, timely, quality medical or podiatric care without discrimination on the basis of race, national origin, handicap, religion, color, creed, sex, age, financial status or other legally protected status;
- (b) Submit to and meaningfully participate in focused, ongoing, and periodic Peer Review of professional competence and skill, as well as quality assurance and

improvement activities, functions, and responsibilities, as may be reasonably requested or otherwise required by the Bylaws, Policies, and Procedures, whether undertaken by the System, ASC, or Medical Staff internally or externally;

- (c) Consistent with subsection (b), above, comply with all ASC, Medical Staff, MSEC, or other Medical Staff committee meeting requests, documentation requests, personal appearance requests, and any requests made to undergo physical or mental health examination if requested as part of a Medical Staff FPPE, investigation, or secondary to any reasonable concern related to the Applicant's or Practitioner's potential impairment and/or ability to safely exercise Clinical Privileges or practice his or her profession;
- (d) Shall comply with applicable Laws regarding the referrals of patients to the ASC and disclosure of financial interests; in particular, Practitioners who have any ownership or financial interest in the ASC shall, before referring an individual to the ASC, disclose in writing to the individual that the Practitioner has a financial interest in the ASC and inform the individual in writing that the individual may choose to be referred to another health care facility; such Practitioners shall require that individuals acknowledge receipt of the notice and Practitioners shall keep a copy of the signed notice;
- (e) Accept committee assignments on a reasonable basis, comply with any attendance requirements established by the Bylaws, Policies, and Procedures, and otherwise make a good faith effort to attend Medical Staff and Committee meetings;
- (f) Comply with all current and applicable Bylaws, Policies, and Procedures, and the Law, including but not limited to, the prohibition on inappropriate fee-splitting arrangements;
- (g) Meaningfully participate in applicable System and ASC accreditation, licensing, and compliance education activities; meaningfully participate in applicable ASC risk management initiatives and activities, and when reasonably requested, meaningfully and timely appear for and participate in applicable ASC risk-management related meetings.
- (h) Successfully complete the Continuing Medical Education ("CME") required by the Practitioner's specialty board and must execute an attestation to that effect. In the event the Practitioner is not board certified, or if the Practitioner's specialty board does not require CME, then the Practitioner must request an exception from the MSEC; (Notwithstanding the foregoing, if the Medical Staff Rules and Regulations provide a specific CME requirement for particular (non-physician) Practitioner-types, the Practitioner must comply with such requirement set forth in the Medical Staff Rules and Regulations);

- (i) Comply with the ASC's communicable disease surveillance and prevention program, including but not limited to, all vaccinations required by the Bylaws, Policies, and Procedures, or by the Law;
- (j) Participate in and successfully complete in a timely manner any System, ASC, or Medical Staff sponsored or required training programs, including but not limited to those related to electronic medical record (EMR) and related clinical system implementation, pass any related program examination or opt-out examination, and submit required program documentation; Applicants and Members shall comply with all rules and regulations, and other applicable policies of the Medical Staff and ASC related to such training programs, including but not limited to implementation and use of EMR systems; Members shall utilize the EMR (to the fullest extent the EMR is available) rather than hard-copy documentation/charting; and
- (k) Report to the COO, by way of Parkview Health Medical Staff Services ( "Medical Staff Services"), **within five (5) business days** of receiving notice of any of the following:
  - (i) The initiation of any challenge or investigation by any state's Medical Licensing Board, other applicable licensing board, or other governmental agency of any professional license or certification and the scope and nature of any charges related to the challenge or investigation;
  - (ii) The initiation of any investigation by the Office of the Inspector General (OIG), Centers for Medicare and Medicaid Services (CMS) or any other state or federal agency, including the scope and nature of any charges relating to the investigation, including any change in eligibility with third-party payers or participation in governmental health care programs, including Medicare and Medicaid, and any sanctions imposed or recommended by the OIG or CMS, and/or the receipt of a professional review organization citation and/or quality denial letter concerning alleged quality problems in patient care;
  - (iii) The initiation of any challenge or investigation by the DEA or any State regarding, or the voluntary or involuntary relinquishment of, any state-controlled substance license or DEA registration;
  - (iv) The involuntary resignation or termination of medical staff membership or clinical privileges at another ambulatory surgery center, hospital. or health care facility (for clarity, "involuntary" in this paragraph additionally includes a voluntary termination or resignation that occurs under the threat of, or to avoid, an involuntary investigation, action and/or termination);

- (v) The voluntary or involuntary limitation, reduction or loss of medical staff membership or clinical privileges at another ambulatory surgery center, hospital, or health care facility;
  - (vi) Receiving an adverse judgment, or upon the monetary settlement of, a professional liability action, including the parties thereto and related allegations;
  - (vii) The investigation, arrest, indictment or conviction with regard to any felony or criminal misdemeanor (minor traffic violations are not required to be reported; however, traffic violations involving (or alleging to have involved) drugs, alcohol, or operating a vehicle while intoxicated are not considered "minor traffic violations" for purposes of these Bylaws and must be reported); or
  - (viii) The suspension or termination of any professional liability insurance coverage or the failure to maintain such coverage at the scope, level or amount as determined by the Governing Board.
- (l) All Applicants and Practitioners shall additionally provide (or shall be provided in the discretion of the ASC) the ASC's Medical Staff Office with (and shall update as may become necessary) an email address that is accurate, current, private, and secure.

#### **2.4. Conditions and Duration of Membership/Clinical Privileges**

- (a) Initial appointments and reappointments to the Medical Staff and the granting of Clinical Privileges shall be made by the Governing Board. The Governing Board shall act on appointments, reappointments, restrictions, or revocations of Membership and/or Clinical Privileges after there has been a determination/recommendation from the Medical Staff as provided for in these Bylaws.
- (b) Medical Staff Membership and Clinical Privilege appointments shall be for a period established by the Governing Board up to a maximum of two (2) years. The MSEC and/or Governing Board may, in their discretion, approve a period of appointment that is less than two (2) years. The approval and imposition of a reduced period of appointment shall constitute an Administrative Action.
- (c) Appointments to the Medical Staff shall confer on the Applicant/Practitioner only such Clinical Privileges as have been granted by the Governing Board in accordance with the Medical Staff Bylaws.
- (d) Every application for Medical Staff Membership and/or for Clinical Privileges at the ASC shall be signed by the Applicant/Practitioner. By submitting an application, each Applicant/Practitioner acknowledges his or her obligation to provide continuous care and supervision of his or her patients and to abide by all applicable Bylaws, Policies, and Procedures and the Law.

## **2.5. Ethics and Ethical Relationships**

Acceptance of Medical Staff Membership and/or Clinical Privileges shall constitute the Practitioner's agreement to strictly abide by all applicable guidelines and opinions set forth in the Code of Medical Ethics of the American Medical Association, the Code of Ethics of the American Osteopathic Association, the Principles of Ethics of the American Podiatric Association and all other applicable ethical guidelines of the Practitioner's licensing body.

## **2.6. Conflict of Interest**

A conflict of interest arises when there is a divergence between a Practitioner's private interests and his/her professional obligations pursuant to the Bylaws, Policies, and Procedures. No Practitioner shall participate in a Medical Staff committee deliberation or vote, nor take any action in his or her capacity as a Medical Staff Officer or in any other Medical Staff leadership capacity if the Practitioner has (a) an actual conflict of interest or (b) a potential conflict of interest sufficient to render the Practitioner incapable of making a determination that is reasonably based upon the pertinent circumstances and that is in the best interests of patient safety, the Medical Staff, the ASC, and the System.

- (a) An actual conflict of interest exists if a Practitioner: (a) is the Practitioner under review (or is a first degree relative or spouse of such Practitioner) or (b) has an admitted or documented material bias against the Practitioner subject of review. All actual conflicts of interest shall be disclosed to the applicable Medical Staff committee, Committee chairperson, Medical Staff President, and/or Medical Director.
- (b) Potential conflicts of interest include, but are not necessarily limited to, the following:
  - (i) A Practitioner was a witness to material events giving rise to a complaint or concern under review or was directly and materially involved in rendering clinical care to the patient subject of review, even though the Practitioner is not the practitioner subject of the review;
  - (ii) A Practitioner previously voted on the same issue/matter in connection with another Medical Staff committee;
  - (iii) A Practitioner is serving as a member of the MSEC and is in direct economic competition with the Practitioner under review such that an Adverse Action (as defined in the Corrective Action and Fair Hearing Plan) recommended or taken against the Practitioner (if Adverse Action is a potential immediate result of the particular review) will result (if approved by the Governing Board when such approval is required) in direct financial gain to the Practitioner;
  - (iv) A Practitioner is involved in a legal conflict with the Practitioner under review.

- (c) Potential conflicts of interest should be disclosed or reported to the applicable Medical Staff committee, Committee chairperson, Medical Staff President, and/or Medical Director. Any person may raise the possibility of a potential conflict of interest. When a potential conflict of interest is raised, it is the responsibility of the applicable Committee (with whom the Practitioner is participating) to consider the matter and determine whether a potential conflict of interest exists sufficient to render the Practitioner incapable of making a determination that is reasonably based upon the pertinent circumstances and that is in the best interests of patient safety, the Medical Staff, the ASC, and the System. If a potential conflict of interest is raised with respect to a Medical Staff Officer, Chairperson, or any other Medical Staff leader in connection with a function unrelated to a particular Committee, the concern should be communicated to and addressed by the MSEC.
- (d) Nothing in this section, without more, is intended to preclude a Practitioner from participating in a review or other matter solely because the Practitioner practices within the same medical specialty as the Practitioner under review or subject of the matter. Similarly, nothing in this section, without more, is intended to preclude a Practitioner from participating in a review or other matter solely because the Practitioner is employed by the System, ASC, or an entity that is affiliated with the System or ASC.
- (e) Notwithstanding the foregoing, as set forth in the Corrective Action and Fair Hearing Manual, no Member that is in direct economic competition with an affected Member may serve on a Hearing Committee, even if such circumstance would not require removal pursuant to this section.
- (f) Nothing herein precludes a Practitioner from recusing himself/herself from participating in a deliberation or vote even though a potential conflict of interest sufficient to strictly require removal pursuant to this section has not been identified.

## **2.7. Medical Staff Application Fees and Dues**

The Medical Staff may elect on a future date (but is not required) to establish and maintain application fees and/or dues. If the Medical Staff elects to do so, then the following provisions (as applicable) shall apply:

- (a) The recommended Medical Staff application fees and annual dues, as applicable, shall be prepared by the Medical Staff President or designee and approved by the MSEC. Medical Staff dues may be category-specific, and may take into consideration budgetary resources and needs of each Medical Staff category. Similarly, a separate fee may be required in relation to requests for temporary Clinical Privileges (to the extent temporary Clinical Privileges are permitted as set forth herein).

- (b) Applicants and Members shall be responsible for timely payment of Application Fees, Membership Dues, and/or Fines (if any) that are required by the Bylaws, Policies, and Procedures. A failure to timely pay such Fees, Dues, and/or Fines (if any and as applicable) may result in Administrative Action as set forth in the Corrective Action and Fair Hearing Manual.

## **2.8. Leave of Absence**

- (a) A Practitioner requesting a leave of absence must submit a written request to the COO, Medical Staff President, and Medical Director, each by way of the Medical Staff Office. During a leave of absence, the Practitioner is not permitted to exercise Clinical Privileges at the ASC, but retains his or her Membership on the Medical Staff, if applicable.
- (b) A request for a leave of absence must state the reasons for, and the approximate duration of, the leave of absence. A leave of absence may be granted for an interval between sixty (60) days and one (1) year, and at the expiration of the first year, an additional (up to) one (1) year leave of absence may be sought; provided however, that if the requesting Practitioner's appointment to the Medical Staff or Clinical Privileges are due to expire during the course of any requested leave of absence, a leave of absence extending beyond the term of appointment shall not be granted. To extend a leave of absence beyond an existing period of appointment, a Practitioner on leave of absence must apply for and successfully receive reappointment, pursuant to the process set forth in these Medical Staff Bylaws, in conjunction with a request for an extension of the leave of absence. Failure to seek reappointment to the Medical Staff or renewal of Clinical Privileges shall result in the Practitioner's voluntary resignation from the Medical Staff and/or relinquishment of Clinical Privileges, as applicable. A Practitioner may not be granted a leave of absence beyond a total of two (2) successive years.
- (c) Except as expressly provided elsewhere in this section, the Governing Board delegates to the COO the authority to make final determinations in connection with requests for leaves of absence and reinstatement. In determining whether to grant a request, the COO shall consult with the Medical Staff President and Medical Director, and shall use his or her best efforts to make a determination within thirty (30) days of the receipt of the written request based on reason(s) for request and any clarifying information requested from the Practitioner.
- (d) No later than thirty (30) days prior to the termination of a leave of absence, the Practitioner may submit to the MSEC a request for reinstatement of Clinical Privileges. The Practitioner must submit a written summary of relevant activities during the leave if the MSEC so requested, as well as all other information reasonably requested by the MSEC. The MSEC shall make a recommendation to the COO concerning the reinstatement. The recommendation should include a plan for FPPE if the Practitioner's leave of

absence was for a period greater than six (6) months and/or if determined by the MSEC to be reasonably appropriate. A Practitioner shall not be reinstated, and therefore shall not be able to exercise Clinical Privileges, until the COO has approved the request, even if this approval process results in a delay of reinstatement. A Practitioner who fails to submit a timely request for reinstatement shall be deemed to have voluntarily withdrawn his or her Medical Staff Membership and/or Clinical Privileges (as applicable). In such event, the Practitioner may thereafter apply as an initial Applicant.

- (e) In the event the MSEC's recommendation constitutes an "Adverse Action," as defined in the Corrective Action and Fair Hearing Manual, then the Practitioner shall be notified of his/her hearing rights (as applicable) pursuant to the Corrective Action and Fair Hearing Manual. Thereafter, the Governing Board shall make a final determination regarding reinstatement.
- (f) In the event the MSEC's recommendation does not constitute an "Adverse Action," the recommendation shall be transmitted to the COO. If the COO concludes that reinstatement is appropriate, then the COO (or designee) will advise the Practitioner of this final determination and the effective date of the reinstatement. The COO (or designee) will also advise the Practitioner of any limitations, changes in staff category, requirements, or other actions that are attendant to, or being taken with respect to, the reinstatement.
- (g) In the event the COO concludes, as part of his/her evaluation, that a limitation, change in staff category, requirement, or other action should be taken that would constitute an "Adverse Action," as defined in the Corrective Action and Fair Hearing Manual, then the COO's determination shall be transmitted to the Governing Board in the form of a recommendation. Thereafter, the Governing Board shall evaluate the matter and make a determination regarding the reinstatement and any associated actions.
- (h) If the Governing Board concludes that "Adverse Action" is appropriate, then the Practitioner shall be notified of his/her hearing rights (as applicable) pursuant to the Corrective Action and Fair Hearing Manual. Following this process, the Governing Board shall take final action.
- (i) If the Practitioner's leave of absence was for health reasons, or if health concerns are reasonably suspected or identified at the time of the requested reinstatement, the Practitioner's request for reinstatement must be accompanied by a report from the Practitioner's pertinent physician(s) or other health care provider(s) indicating that the Practitioner is physically and/or mentally capable of resuming a ASC practice and safely executing the Membership and Clinical Privileges requested. The COO, MSEC, and/or Governing Board may additionally request that the Practitioner undergo physical and/or mental evaluation (at the Practitioner's cost), with the complete results of such evaluation made available to the COO, MSEC, and Governing Board as part of the evaluation for reinstatement.

- (j) A Practitioner on a leave of absence is required to pay all Medical Staff dues and other required fees (if applicable) pursuant to Section 2.7, above, and to maintain sufficient professional liability insurance pursuant to Section 2.2.2, above.
- (k) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that a Practitioner has not demonstrated good cause for a leave of absence or where a request for extension is otherwise not granted, the determination shall constitute an Administrative Action. A determination made regarding reinstatement, unless constituting an "Adverse Action" pursuant to the Corrective Action and Fair Hearing Plan, shall also constitute an Administrative Action. Further, given the evaluation and meetings that may be necessary in order to fully evaluate a requested return from Leave of Absence, nothing here requires the Medical Staff and/or Governing Board to complete their evaluation, and arrive at a final determination, within thirty (30) days of the Practitioner's request. Rather, the Medical Staff and Governing Board, as applicable, shall consider the matter in a reasonably prompt manner.

## **2.9. Medical Staff Year**

The Medical Staff Year is from January 1 to December 31.

### **ARTICLE III**

#### **CATEGORIES OF THE MEDICAL STAFF**

### **3.1. The Medical Staff**

The Medical Staff shall be organized into the categories set forth below. All Members of the Medical Staff must satisfy the basic qualifications and responsibilities as applicable and set forth in Sections 2.2 and 2.3 of this Manual. Members must also satisfy such other qualifications that are specific to each category. All initial Medical Staff category placements shall be provisional in nature, as set forth below. Based upon the qualifications for each category, Members may be administratively reclassified to the category for which they are eligible should the Member's status or eligibility change during an appointment period and/or as a result of amendment(s) to these Medical Staff Bylaws, which effectively require such reclassification.

### **3.2. The Active Staff**

The Active Staff is generally responsible to the Governing Board for the quality of medical care and treatment of patients in the ASC and the overall organization of the Medical Staff. Members of the Active Staff are expected to contribute to the organizational and administrative affairs of the Medical Staff.

#### **3.2.1. Qualifications**

The Active Staff shall consist of Physicians and Podiatrists who meet the following requirements in the discretion of the Governing Board upon recommendation from the MSEC:

- (a) Are, in the discretion of the MSEC and Governing Board, regularly available to provide continuous care to his/her patients at the ASC (individually or through a qualified alternate); and
- (b) Except as may be provided for the Radiology Director, are employed and/or contracted by Orthopaedics Northeast, P.C.

### **3.2.2. Responsibilities**

Members of the Active Staff shall:

- (a) Regularly attend and participate in meetings of the Medical Staff and serve in Medical Staff committee and leadership roles if requested;
- (b) Meet established continuing medical education requirements;
- (c) Actively participate in quality assessment and improvement activities of the Medical Staff when requested;
- (d) Pay Medical Staff dues, fees, and fines (if applicable);
- (e) Maintain accurate, legible, timely and complete medical records; and
- (f) Demonstrate the capability to provide continuous and timely patient care to the satisfaction of the MSEC and Governing Board.

### **3.2.3. Prerogatives**

Members of the Active Staff may:

- (a) Exercise such Clinical Privileges as are granted by the Governing Board; these Clinical Privileges may include permission to admit patients to the ASC;
- (b) Participate in ASC and Medical Staff educational opportunities;
- (c) Serve and vote on Medical Staff committees;
- (d) Vote on all matters presented at general and special meetings of the Medical Staff; and
- (e) Serve as a Medical Staff Officer.

## **3.3. The Courtesy Staff**

### **3.3.1. Qualifications**

The Courtesy Staff shall consist of Physicians who maintain Clinical Privileges at the ASC and who, in the discretion of the MSEC and Governing Board, are regularly available to provide continuous care to his/her patients at the ASC, but who do not otherwise meet the requirements to serve on the Active Staff, as set forth above.

### **3.3.2. Responsibilities**

Members of the Courtesy Staff shall:

- (a) Make reasonable attempts to attend and participate in meetings of the Medical Staff;
- (b) Maintain a sufficient level of activity at the ASC to comply with the Medical Staff's Policy for Ongoing Professional Practice Evaluation;
- (c) Meet established continuing medical education requirements;
- (d) Participate in and cooperate with quality assessment and improvement activities of the Medical Staff;
- (e) Pay Medical Staff dues, fees, and fines (if applicable);
- (f) Maintain accurate, timely and complete medical records; and
- (g) Demonstrate the capability to provide the continuous and timely care to the satisfaction of the MSEC and Governing Board.

### **3.3.3. Prerogatives**

Members of the Courtesy Staff have the same prerogatives as Members of the Active Staff, except that Members of the Courtesy Staff:

- (a) May not serve as a Medical Staff Officer;
- (b) May attend, but not vote at, general or special meetings of the Medical Staff;
- (c) May serve on Medical Staff committees, but only if requested by the MSEC; and
- (d) May vote on Medical Staff committees, but only if requested by the MSEC.

## **3.4. Advanced Practice Professionals**

APPs in a scope of practice that have been authorized by the Governing Board, as set forth on Appendix A to these Bylaws (as may be updated from time to time), are not eligible for Medical Staff Membership, but may be granted (if otherwise eligible) Clinical Privileges commensurate with the APP's particular scope of practice and state-issued license, but subject to all terms, conditions, and limitations set forth in the Bylaws, Policies and Procedures. APPs may serve

and/or participate on ASC and/or Medical Staff committees if requested by the Governing Board or MSEC and if appropriate in relation to the APP's scope of practice.

### **3.5. Focused Professional Practice Evaluation/Reclassification of Medical Staff Category**

Practitioners receiving new or additional Clinical Privileges shall undergo a period of Focused Professional Practice Evaluation, consistent with Section 5.13 below, in order evaluate the Member for (1) proficiency in the exercise of Clinical Privileges initially granted and (2) overall eligibility for continued staff Membership in the assigned category. The extent, nature and duration of the period of FPPE, or any extension of such FPPE, shall be determined by the MSEC. Following the period of initial FPPE, or at any time thereafter, Members may be administratively reclassified to a different Medical Staff category, or otherwise removed from Membership, in the event the MSEC determines the Practitioner has failed to demonstrate compliance with an objective requirement to maintain such classification. Any such reclassification or removal, unless made as part of a Professional Review Action, shall be considered an Administrative Action.

## **ARTICLE IV**

### **PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT OF MEMBERSHIP AND/OR CLINICAL PRIVILEGES**

#### **4.1. Pre-Application Procedures**

##### **4.1.1. Form Preparation**

The MSEC, with the assistance of the ASC's Medical Staff Office, shall be responsible for developing, reviewing, and recommending any changes to application forms, including any application request form that may be utilized, appointment, reappointment, and updating forms. All forms and revisions thereto shall be reviewed and approved by the MSEC and the Governing Board, and shall conform to any applicable Indiana state statutes and regulations that mandate the use of particular forms or specific content.

##### **4.1.2. Request for Application/Pre-Application Form**

- (a) In the event an individual requesting an Application is not employed or contracted by Orthopaedics Northeast, P.C., as a precondition to receiving and submitting an application for Medical Staff Membership and/or Clinical Privileges, the individual must first request that an exception be made by the Governing Board as set forth in Section 2.2.2., above. In doing so, the individual must complete the ASC's preferred/prevaling form of pre-application, inclusive of all additional or supporting information that may be requested by the ASC.
- (b) Pre-applicants may be administratively denied an application in the event the Governing Board elects to not make an exception as set forth in Section 2.2.2., above, or in the event it is otherwise apparent that the pre-applicant does not

meet one or more other basic eligibility requirements for Medical Staff Membership and/or Clinical Privileges, as applicable. Any such administrative denial constitutes an Administrative Action.

- (c) Any pre-applicant denied an application shall receive written notice of this determination. Otherwise, and if the Governing Board elects to make an exception as set forth in Section 2.2.2., above, the pre-applicant shall be provided an application.
- (d) Receipt of an application does not, however, preclude a subsequent finding of administrative ineligibility or otherwise in any fashion guarantee that Medical Staff Membership and/or Clinical Privileges, as applicable, will be granted.

## **4.2. Application for Initial Appointment and/or Clinical Privileges**

### **4.2.1. Application Form**

Each application for appointment to the Medical Staff and/or Clinical Privileges, as applicable, shall be in writing, submitted on the prescribed form, and signed by the pre-applicant. Electronic submission of such forms, as directed by the Medical Staff Office, shall be acceptable. Once a signed and completed application form has been received and accepted by Medical Staff Office (or the ASC's CVO if such function is delegated to a designated CVO), the pre-applicant shall be considered an Applicant.

### **4.2.2. Content**

The ASC's form of application includes, at a minimum, the following requests for information. The ASC may supplement its application form content by general or specific requests for information.

- (a) Acknowledgment and Agreement. A statement that the Applicant has received or has had access to the Bylaws, Policies, and Procedures, has read and understands the Bylaws, Policies, and Procedures (or has otherwise elected to his/her potential detriment not read/review the Bylaws, Policies, and Procedures), and agrees to be bound by the Bylaws, Policies, and Procedures, including but not limited to all applicable provisions in all matters relating to consideration of his or her request for initial or continuing Medical Staff Membership and/or Clinical Privileges.
- (b) Qualifications and Professional History. Detailed information concerning the Applicant's qualifications, demonstrated current competency and professional performance, including information regarding the qualifications specified in the Medical Staff Governance and Credentialing Manual and of any additional qualifications established by the Medical Staff or Governing Board for the Clinical Privileges being requested. Additionally, any faculty membership at any medical or other professional school; names and locations of past or

current professional employment; and names and locations of any other past or current hospitals or other licensed health facilities where the Applicant has applied or received medical staff membership and/or clinical privileges.

- (c) Requests. A request stating the Medical Staff category and Clinical Privileges for which the Applicant desires to be considered.
- (d) References. The names of at least two (2) professional peers and one (1) administrative reference who have personal knowledge of the Applicant's current clinical skills, abilities, character, ethics, judgment, professional performance, and clinical competence or have otherwise been responsible for professional observation of Applicant's professional services. For purposes of this section, a "peer" is defined as an individual in the same professional discipline as the Applicant. (MD and DO are considered equivalent). A "peer" does not include a residency director, fellowship director, or personal relatives. At least one peer reference should be an individual that is within the same specialty as Applicant. For purposes of this section, a Physician (with at least equivalent Clinical Privileges as an Applicant/Member who is a Nurse Practitioner or Physician Assistant) shall be considered to be within the same discipline and specialty as the Nurse Practitioner or Physician Assistant. With respect to new physician graduates, at least one (1) professional reference (of the three references required above) must be a Residency or Fellowship Program Director.
- (e) Professional Sanctions. Information regarding whether any of the following have ever been or are in the process of being denied, revoked, suspended, reduced, restricted, probationary, not renewed, or voluntarily relinquished or voluntarily not exercised shall be reported in detail:
  - (i) Medical Staff Membership status and/or Clinical Privileges at any other hospital or health care facility;
  - (ii) Membership/Fellowship in local, state or national professional organizations;
  - (iii) Board Certification or related Board Certification status;
  - (iv) License to practice any profession in any jurisdiction; and
  - (v) Any state Controlled Substance License or Drug Enforcement Administration Controlled Substances Registration Certificate (DEA).

(f) Additional Disclosures.

The Applicant shall disclose:

- (i) Any and all malpractice suits, settlements and judgments to which he or she is or has been a party;
  - (ii) Any remedial, corrective or disciplinary action of any kind taken by any hospital, Medical Staff, professional organization, licensing body or governmental agency;
  - (iii) Any circumstance where employment, Medical Staff membership and/or clinical privileges were reduced, suspended, diminished, revoked, refused, voluntarily not exercised, or limited at any hospital or other health care facility, whether voluntarily or involuntarily;
  - (iv) Any circumstance where he or she withdrew an application for appointment/reappointment and/or clinical privileges, or resigned from a medical staff or clinical privileges to avoid an investigation before action by a hospital's or health facility's medical staff or governing board;
  - (v) Any past or current investigations due to inappropriate conduct, disruptive behavior, or unprofessional conduct (e.g., sexual harassment);
  - (vi) Any past or current investigations, focused individual monitoring, review, or audits related to the quality of care or competency;
  - (vii) All other information residing in the National Practitioner Data Bank;
  - (viii) All healthcare related employment/appointments (work history);
  - (ix) All information related to the investigation, arrest, indictment or conviction with regard to any felony or misdemeanor;
  - (x) Current criminal background check;
  - (xi) All information as to the Applicant's medical education and post-graduate training; and
  - (xii) Any information requested on the supplemental form utilized as part of the Medical Staff Membership and/or Clinical Privileges application process.
- (g) Notification of Release of Immunity Provisions. Statement notifying the Applicant of the scope and extent of the authorization, confidentiality, immunity and release provisions contemplated by these Medical Staff Bylaws.

- (h) Administrative Remedies. A statement that the Applicant agrees that if an adverse decision is made with respect to his or her Medical Staff Membership status and/or Clinical Privileges, the Applicant will exhaust or waive any administrative remedies afforded by the Medical Staff Bylaws prior to initiating any purported request for judicial review or other legal action (notwithstanding any other legal and/or factual deficiency in such action).
- (i) Financial Responsibility. Evidence that the Applicant has secured or currently maintains professional liability insurance in a form and in such amounts as prescribed by the Governing Board.
- (j) Obligation to Update. The application form includes a statement that the Applicant acknowledges that he or she has the burden of providing any and all information necessary to process the application as determined in the discretion of the MSEC or Governing Board; that he or she is solely responsible for supplementing his or her application during the application process, in addition to the disclosure requirements set forth in these Medical Staff Bylaws, to ensure the absolute accuracy of all statements and information contained therein as soon as this information becomes known but, in any event, before a final appointment or reappointment decision is made; and that any false or misleading information provided by a pre-applicant, Applicant, Member, or APP during the pre-application, application, appointment, reappointment, or renewal process may be treated as a voluntary relinquishment or otherwise serve as grounds for Administrative Action, corrective action, and/or termination of the credentialing process, as applicable.
- (k) Consent and Authorization to Share Information. As a condition of Membership and/or Clinical Privileges, the Applicant agrees that any quality, Peer Review, and other related information that is collected as part of the appointment/reappointment or privileging process, as well as any other Peer Review activities, may be shared with other health care organizations and entities and their designees, including without limitation those that are administratively and clinically affiliated with the ASC and Applicant/ for purposes related to credentialing, privileging, managed care participation or any other System quality review or service line activities, and any other health care facility or organizations at or for which the Applicant seeks to practice.

#### **4.2.3. Additional Content – Delegated Credentialing**

The ASC may elect, in its discretion, to perform delegated credentialing for health plans by and through the Medical Staff credentialing process outlined in these Bylaws. In the event the ASC makes such election, additional terms, conditions, and application content may be incorporated into the credentialing process, consistent with the ASC's applicable policy for such delegated credentialing, for this particular purpose in order to ensure compliance with health plan credentialing and related accreditation requirements.

### 4.3. Effect of Application

By applying for Membership and/or Clinical Privileges, and in addition to any other conditions, commitments or releases contained throughout the Bylaws, Policies, and Procedures, each Applicant:

- (a) Attests to the accuracy and completeness of all information on his or her application or accompanying documents and agreement that any inaccuracy, omission, or misrepresentation, whether intentional or not, may be grounds for termination of the application process, which is an Administrative Action. Each Applicant further acknowledges that if a material inaccuracy, omission or misstatement is discovered after an individual has been granted appointment and/or Clinical Privileges, the individual's appointment and Clinical Privileges shall lapse effective immediately upon notification of the individual. All determinations regarding whether an accuracy, omission or misrepresentation is material in nature shall be made by the MSEC in its sole discretion, and shall constitute an Administrative Action;
- (b) Signifies willingness to appear for interviews in regard to his or her application;
- (c) Authorizes ASC and Medical Staff representatives to consult with others who have been associated with him/her and/or who may have information bearing on the Applicant's competence and qualifications;
- (d) Consents to ASC and Medical Staff representatives inspecting all records and documents that may be material to an evaluation of professional qualifications and competence to carry out the Clinical Privileges requested, of physical and mental health status and of professional ethical qualifications;
- (e) Releases from liability, extends absolute immunity to, and agrees not to sue the System, the ASC, the ASC's agents, the Governing Board, the Medical Staff, any Member of the Medical Staff, and any Medical Staff committee for their Peer Review activities, including the evaluation of the applicant, any determinations made or actions taken with respect to the applicant, and any use or communication of privileged or confidential information concerning the applicant's competence, professional ethics, character, physical and mental health, emotional stability, and other qualifications for Medical Staff appointment and Clinical Privileges (as applicable);
- (f) Releases from any liability, extends absolute immunity to and agrees not to sue any individuals or organizations who provide information in good faith to ASC and Medical Staff representatives concerning the Applicant's competence, professional ethics, character, physical and mental health, emotional stability and other qualifications for Medical Staff appointment and Clinical Privileges;
- (g) Authorizes the System, ASC and Medical Staff, and their designees to provide other hospitals, medical associations, the National Practitioner Data Bank,

licensing boards, affiliated entities of System (or its successor), other health care facilities or organizations of health professionals with any information relevant to such matters that the ASC may have concerning him or her, and releases ASC and Medical Staff representatives from liability for so doing; and

- (h) In addition to the preceding paragraph (g), acknowledges and agrees to the ASC's policies and procedures for appropriately sharing information, including but not limited to Peer Review information, with other affiliated entities and with third parties who are permitted to receive such information; each Applicant/Member hereby agrees: (a) to execute and comply with any Authorization and Release documents that may be requested by the ASC and/or Medical Staff to facilitate the sharing of such information, and (b) that such information, when shared or exchanged, may be evaluated and utilized as part of the appointment/reappointment or privileging process, may form the basis for a request for corrective action and/or an adverse action, and may also be exchanged as part of the preliminary review and/or investigation processes set forth in the Medical Staff Bylaws.

#### **4.4. Processing the Application**

All requests for Medical Staff Membership and/or Clinical Privileges by Physicians, Podiatrists, and APPs, as applicable, will be processed pursuant to the procedures set forth in these Medical Staff Bylaws. All requests for permission to provide patient care services by AHPs will be processed and evaluated by the ASC through its Human Resources Department or other designated ASC office in a manner consistent with the ASC's pertinent policies and procedures. The ASC may additionally delegate, in its discretion, certain credentialing verification functions pertinent to a CVO.

##### **4.4.1. Applicant's Burden**

The Applicant shall have the burden to produce adequate information for a proper evaluation of the Applicant's licensure status, experience, education, background, training, current competence, demonstrated ability, physical and mental health status, emotional stability, character, and judgment, and of resolving any doubts about these or any of the other basic qualifications specified or referenced throughout the Medical Staff Bylaws. All information required to be provided or disclosed, including supplemental requests by the applicable MSEC or Governing Board, must be submitted within thirty (30) days of the request or within the timeframe otherwise specified by the requesting party or otherwise set forth in the Bylaws, Policies, and Procedures. If an Applicant fails to meet this burden, the application will be deemed withdrawn and closed. Unless waived by the MSEC or Governing Board for good cause, the Applicant will not be eligible to submit a new application for a period of one (1) year from the date the initial application was deemed to be withdrawn.

##### **4.4.2. Verification of Information/Complete Application.**

- (a) The Applicant shall return an application that contains all requested information to Medical Staff Office or a designated CVO within sixty (60) days from the date the application was initially mailed, or otherwise provided to, the Applicant. Otherwise, the application shall be deemed automatically withdrawn.
- (b) The ASC and Medical Staff representatives, in conjunction with the CVO (if applicable), shall in timely fashion seek to collect and obtain primary source verification of the Applicant's licensure history, medical education and postgraduate training, malpractice insurance history, board certification status, sanctions and disciplinary actions, criminal history, employment/appointment history, professional references, and other qualification evidence submitted, including, but not limited to, a query of the National Practitioner Data Bank, AMA and AOA (as applicable), the Office of the Inspector General, and Medicare/Medicaid Exclusion list. The ASC and Medical Staff representatives, in conjunction with the CVO (if applicable), will also request from the Indiana Professional Licensure Agency all information concerning the licensure status and any disciplinary action taken against an Applicant's license.
- (c) An Applicant shall be notified of any problems or omissions in obtaining the information required, and it shall then be the Applicant's obligation to obtain or provide the required information.
- (d) Once all requested information has been received and verified, the application shall be deemed complete. The application and all supporting information and documentation (referred to herein as a "Complete Application") shall then be forwarded to the MSEC pursuant to the process set forth below. In the event the MSEC or Governing Board (or their respective designees) determine, at any point thereafter, that additional documentation or information is necessary to fully evaluate the application, the Applicant shall have the burden to timely provide (or cause to be provided) such documentation/information. The application shall be deemed incomplete upon such a determination/request and until such time as the Applicant has timely provided all requested documentation and information. Incomplete applications may be deemed withdrawn and closed as set forth above in Section 4.4.1. Any such closure shall constitute an Administrative Action.

#### **4.4.3. MSEC Review and Recommendation**

- (a) Within thirty (30) days after receiving a complete application, inclusive of all supporting materials, and unless additional time is reasonably required in the discretion of the MSEC Chairperson, the MSEC shall review the application, all supporting materials, and shall conduct any further investigation of the Applicant as determined to be warranted. The MSEC may additionally (but is not required to) conduct a personal interview (directly or through MSEC representative(s)) with the Applicant if it deems an interview is appropriate.

- (b) Once the MSEC has completed its review of the application, and in so doing has considered the licensure status, training/education, professional competence, character, judgment, experience, health status, ethical standing of the Applicant and other applicable qualifications of the Applicant, it shall determine whether to:
  - (i) Recommend to the Governing Board that the Applicant be appointed to the Medical Staff and/or that specific Clinical Privileges be granted; or
  - (ii) Recommend to the Governing Board that some or all elements of the Medical Staff Membership and/or Clinical Privileges sought by the Applicant be restricted and/or denied.
- (c) If the MSEC's recommendation includes or constitutes an "Adverse Action" (as set forth in the Corrective Action and Fair Hearing Manual), the Medical Staff President (or designee) shall deliver a Special Notice of Adverse Action to the Applicant, and the Applicant shall be afforded hearing and appeal rights as set forth in the Corrective Action and Fair Hearing Manual before the MSEC's final recommendation is transmitted to the Board. A copy of the Special Notice shall be provided to the COO and Medical Director.
- (d) The Medical Staff President, or his/her designee, shall thereafter present the MSEC's recommendation for Medical Staff Membership and/or Clinical Privileges (as applicable) to the Governing Board for its consideration, including any special condition(s) to be attached to the appointment (if any).
- (e) The MSEC shall conduct its review as a Peer Review Committee, and shall do so with the intent of reducing morbidity and mortality, and to improve the quality of patient care provided at the ASC.

#### **4.4.4. Governing Board Action**

Upon reviewing the application and all supporting material forwarded by the MSEC, at its next regular meeting, the Governing Board shall, in whole or in part, accept or decline to accept the recommendation of the MSEC. Alternatively, it may refer the application back to the MSEC for further consideration, stating the reasons for this action and setting a time limit within which any subsequent recommendation shall be made.

Whenever the Governing Board's decision is contrary to or materially different from the MSEC's final recommendation, the Governing Board shall notify the MSEC. In such circumstances, if the MSEC or the Governing Board so request, the Governing Board shall first submit the matter to a Joint Conference Committee which shall report its recommendation to the Governing Board within fourteen (14) days of the action proposed by the Governing Board, unless additional time is reasonably required. Under such circumstances, the Governing Board shall consider the report of the Joint

Conference Committee and then take its tentative final action. The Governing Board is responsible for the final decision, based on Medical Staff recommendations, regarding an individual's Medical Staff Membership and/or the grant of Clinical Privileges (as applicable). In rendering its final decision regarding a Complete Application, the Governing Board shall recognize the primary role of the Medical Staff in reviewing the qualifications of Medical Staff Applicants. The Governing Board's determinations with respect to such recommendations shall be based on the information and recommendations submitted by the Medical Staff, and other relevant information, provided, however, that the recommendations of the Medical Staff shall be given appropriate weight and authority given its expertise in these areas; and provided further that while the Governing Board has the ultimate authority with respect to such decisions, the Governing Board shall conduct its review and reach a final determination as a Peer Review committee and shall do so with the intent of reducing morbidity and mortality and improving the quality of patient care provided at the ASC.

All credentialing recommendations and determinations, pursuant to the process set forth above, shall be uniformly applied.

#### **4.4.5. Notice of Final Decision**

- (a) If the Governing Board's action is favorable to the Applicant, it shall become effective as a final determination. Notice of final determinations shall be communicated to the Medical Staff President and the Medical Staff Office, who shall promptly notify the Applicant in writing. Written notification to the Applicant shall be within sixty (60) days of the determination. The written notice should include, as applicable, the Medical Staff category to which the Applicant is appointed, the Clinical Privileges he or she may exercise, and any special condition(s) attached to the Membership and/or Clinical Privileges.
- (b) If the decision of the Governing Board independently constitutes an "Adverse Action" (as set forth in the Corrective Action and Fair Hearing Manual), the COO (or designee) shall send a Special Notice of Adverse Action to the Applicant, and the Applicant shall be afforded hearing and appeal rights as set forth in the Corrective Action and Fair Hearing Manual. A copy of the Special Notice shall be provided to the COO and Medical Staff President.

#### **4.4.6. Reapplication After Adverse Appointment of Privileges Decision**

An Applicant who has received a final adverse decision regarding appointment, reappointment and/or Clinical Privileges, or has otherwise had his or her Medical Staff Membership and/or Clinical Privileges at the ASC revoked or terminated by way of an Adverse Action, shall not be eligible under any circumstances to reapply for Medical Staff Membership or for Clinical Privileges for a period of five (5) years from the date of the final action. Following such period, the Applicant shall then additionally be subject to the basic eligibility requirement set forth in Section 2.2.2.(p). In the event the Applicant requests that an exception be made, as permitted by Section 2.2.2.(p),

the MSEC and Governing Board (in their discretion) may consider and rely upon any relevant circumstances or information, including but not limited to, the circumstances and information giving rise to the prior Adverse Action(s), as well as the type, nature, and scope of the prior Adverse Action(s).

#### **4.5. Reappointment/Renewal Process**

##### **4.5.1. Information Form for Reappointment**

The Medical Staff Office or a designated CVO shall, not less than ninety (90) days prior to the expiration date of a Medical Staff appointment and/or expiration of Clinical Privileges, provide the Practitioner with an appropriate reappointment or renewal application form for use in considering reappointment and/or renewal of Clinical Privileges. Each Practitioner who desires reappointment or renewal shall, not less than sixty (60) days prior to such expiration date, submit a fully completed reappointment/renewal application form to the Medical Staff Office or CVO, as applicable, in addition to any other requested information. In the event the ASC is unable to fully process a request for reappointment or renewal (as applicable) prior to the expiration of a Practitioner's then current term of appointment and/or Clinical Privileges (as applicable), the Practitioner's Medical Staff Membership and Clinical Privileges (as applicable) shall lapse, and thereafter, the Practitioner must reapply for Medical Staff Membership and/or Clinical Privileges pursuant to the initial appointment process.

##### **4.5.2. Content of Reappointment Application Form**

The content of the reappointment/renewal application form shall include, but not be limited to, the applicable information set forth in Section 4.2.2, above. Notwithstanding the foregoing, the timeframe for such requests may be limited to the prior three year period of appointment, and the results of Ongoing Professional Practice Evaluation conducted at the ASC with respect to the Practitioner over the three year period of reappointment may be utilized, in the discretion of the MSEC, in lieu of the peer references required by Section 4.2.2(d), above.

#### **4.6. Processing of Reappointment and/or Renewal of Clinical Privileges**

##### **4.6.1. Reappointment Burden**

The Practitioner applying for reappointment and/or Clinical Privileges shall have the same burden of producing adequate information and resolving doubts as provided in Section 4.4.1, above.

##### **4.6.2. Verification of Information/Complete Application**

The same provisions, obligations, and procedures set forth in Section 4.4.2, above, regarding verification of information/complete applications for initial Applicants shall apply to Practitioners seeking reapplication or renewal.

#### **4.6.3. MSEC and Governing Board Review/Action**

The same provisions, obligations, and procedures set forth in Sections 4.4.3 through 4.4.8, above, shall be followed. For purposes of reappointment or renewal, the term “appointment” as used in those Sections shall be read as “reappointment.” Similarly, “Applicant” shall mean and refer to any Practitioner that is applying for renewal and/or reappointment to the Medical Staff and/or for Clinical Privileges.

#### **4.6.4. Basis for Recommendations**

Each recommendation concerning the reappointment of a Medical Staff Member and the Clinical Privileges to be granted upon reappointment, including renewal of Clinical Privileges for an APP, shall be based upon documented evidence of: such Practitioner's eligibility, professional ability and clinical judgment in the care and treatment of patients, professional ethics, discharge of Medical Staff obligations, discharge of Clinical Privileges obligations, compliance with the Bylaws, Policies, and Procedures, cooperation with other Practitioners and with patients, ability to safely practice, the Practitioner's reasonable participation in continuing education activities relevant to his or her Clinical Privileges, and any other matters determined to bear on the Practitioner's ability and willingness to contribute to quality patient care in the ASC. Relevant data generated through OPPE, FPPE, and other Peer Review processes at the ASC will also be considered.

#### **4.7. Requests for Modification of Membership Status or Clinical Privileges**

A Practitioner may, either in connection with reappointment or renewal or at any other time, request modification of Medical Staff Category or Clinical Privileges. A requested change in Medical Staff Category shall be transmitted to the Medical Staff President or designee, whereas a requested change in Clinical Privileges shall be transmitted to the MSEC. All requests for additional Clinical Privileges must be accompanied by evidence of the Practitioner's education, training, experience and competence to perform the specific Clinical Privileges requested. Such application shall be processed in substantially the same manner as provided in Section 4.6, above, for reappointment.

#### **4.8. Option to Expedite**

Notwithstanding the credentialing review process set forth above in Section 4.4, the Medical Staff may elect to utilize an expedited review process in relation to “clean” applications, as set forth below.

##### **4.8.1. Applications Eligible for Expedited Credentialing**

Only “clean” applications are available for expedited credentialing. A clean application is a Complete Application that meets all applicable criteria and any applicable regulatory and accrediting agency standards for expedited review. Accordingly, an application is not a clean application if at the time of appointment or granting of Clinical Privileges, or if since the time of last reappointment, any of the following has occurred:

- (a) The Applicant or Practitioner submits an incomplete application;
- (b) There is a current challenge or a previously successful challenge to the Applicant's or Practitioner's licensure or registration;
- (c) The Applicant or Practitioner has received an involuntary termination of medical staff membership at another organization;
- (d) The Applicant or Practitioner has received involuntary limitation, reduction, restriction, denial, loss of Clinical Privileges or is otherwise under current focused Peer Review or investigation;
- (e) There has been a final judgment that is adverse to the Applicant or Practitioner in a professional liability action; or
- (f) There is a reasonable concern about the Applicant or Practitioner's health status.

#### **4.8.2. Expedited Review Process**

- (a) In the event the Medical Staff Office determines that an application is a clean application, the application may be forwarded to an Expedited Review Committee, comprised of the Medical Staff President and Medical Director (or their authorized Physician designees).
- (b) The Expedited Review Committee is hereby authorized by the Medical Staff Executive Committee to make final credentialing recommendations in relation to clean applications as a subcommittee and on behalf of, and with the full authority of, the MSEC. Stated differently, the Expedited Review Committee hereby serves as the MSEC in relation to such applications.
- (c) The Expedited Review Committee, serving as a Peer Review Committee, shall meet in person or virtually to consider the clean application. In conducting its review, the committee shall have all of the same rights as set forth above in Section 4.4.4.
- (d) If the Expedited Review Committee unanimously approves the application, such approval, along with the Complete Application, shall be forwarded to an authorized Governing Board subcommittee, as set forth below. If the Expedited Review Committee determines at any point that the application is not a clean application or if there is not a unanimous approval of the application, then the application shall be redirected to the MSEC for routine credentialing review as set forth above in Sections 4.4.4. through 4.4.6.
- (e) Clean applications that are unanimously approved by the Expedited Review Committee will thereafter be considered by an authorized subcommittee of the Governing Board, which consists of the COO and one (1) other member of the Governing Board (as designed by the Board). This subcommittee shall at

all times function as a Peer Review Committee and shall have the full authority of the Board to make final credentialing determinations.

- (f) If the subcommittee of the Board unanimously approves the application, notice shall be provided in the same manner as set forth above in Section 4.4.7. If the subcommittee of the Board determines at any point that the application is not a clean application or if there is not a unanimous approval of the application, then the application shall be redirected to the MSEC for routine credentialing review as set forth above in Sections 4.4.4. through 4.4.6.

## **ARTICLE V**

### **CLINICAL PRIVILEGES**

#### **5.1. Exercise of Clinical Privileges**

Any Practitioner providing direct clinical services at the ASC shall, in connection with such practice, be entitled to exercise only those Clinical Privileges specifically granted to him/her by the Governing Board. In the event a Practitioner or Applicant is not eligible for Medical Staff Membership, but is otherwise eligible for Clinical Privileges at the ASC (such as an eligible APP), the MSEC may recommend and the Governing Board may approve such Clinical Privileges in order to permit the Practitioner to render clinical services at the ASC in accordance with the Bylaws, Policies, and Procedures.

All Clinical Privileges and services must be within the scope of the Practitioner's license, certificate or other legal authority authorizing him/her to practice in Indiana, and must be consistent with any other applicable restrictions.

Practitioners with admitting Clinical Privileges will ensure that patients are admitted only for the purpose of surgical procedures and services. All such surgical procedures shall be limited to those surgical procedures authorized by the Governing Board and that do not require a stay at the ASC for a period longer than twenty-four (24) hours.

## **5.2. General Delineation of Clinical Privileges**

### **5.2.1. Requests**

- (a) Each application for appointment and reappointment to the Medical Staff and/or for Clinical Privileges must contain a request for the specific Clinical Privileges desired by the Applicant/Practitioner.
- (b) A request for a modification of Clinical Privileges must be supported by documentation of appropriate training and/or experience supportive of the request and must be consistent with all criteria that have been delineated and established by the Governing Board.
- (c) Any request for Clinical Privileges for which there are no approved requirements may be held for a period of up to one hundred twenty (120) days, or for a longer period if determined to be necessary by the Governing Board. During this time, the MSEC may create requirements and formulate the necessary criteria for Clinical Privileges under which the request may be processed for approval by the Governing Board. All requirements for Clinical Privileges will consist of baseline criteria specifying the minimum education, training, experience, and evidence of competency required. All Clinical Privileges are subject to, in the final discretion of the Governing Board, the reasonable resources and capabilities of the ASC.

### **5.2.2. Basis for Clinical Privileges Determination**

Requests for Clinical Privileges shall be evaluated through the initial appointment and reappointment process outlined above, shall be based on the Applicant's/Practitioner's education, training, certifications, experience, demonstrated ability, judgment, compliance with the Bylaws, Policies, and Procedures, and should take into consideration the resources and capabilities of the ASC. If available, the basis for Clinical Privileges determinations shall also include clinical performance as observed or reviewed by the ASC's performance and/or quality improvement programs. In addition, other factors to be considered shall be the results of focused and ongoing professional practice monitoring and evaluation activities, other quality assurance activities, and whether the Applicant or Practitioner meets any applicable patient contacts requirement. A Clinical Privileges determination shall also be based on pertinent information concerning clinical performance obtained from other sources, such as peers of the Practitioner, and/or from other institutions, especially from health care settings where the Practitioner exercises the clinical privileges that are requested. This information shall be maintained in the quality file established for each Practitioner and shall be the Practitioner's burden to provide, or cause to be provided, if requested.

## **5.3. Special Considerations for Anesthesia Clinical Privileges/Services**

The Medical Staff shall provide anesthesia services that meet the needs of the patient, within

the scope of the services offered, in accordance with acceptable standards of practice, and such services must be under the direction of a licensed physician with specialized training or experience in the administration of anesthetics. The Medical Staff shall write and implement policies and procedures, as approved by the Governing Body of the ASC, which include, but are not limited to, the following:

- (a) A requirement that a licensed physician with specialized training or experience in the administration of an anesthetic supervise the administration of the anesthetic to a patient and remain present in the ASC during the surgical procedure, except when only a local infiltration anesthetic is administered.
- (b) The use of the following:
  - (i) Monitored anesthesia care (MAC);
  - (ii) General anesthesia;
  - (iii) Regional anesthesia;
  - (iv) Local anesthesia;
  - (v) Topical anesthesia (sprays);
  - (vi) Intravenous anesthesia.
- (c) Anesthesia shall only be administered by a Practitioner granted Clinical Privileges at the ASC and who is a:
  - (i) qualified physician with appropriate training, experience, and privileges;
  - (ii) Practitioner holding a current permit to administer a specific form of anesthesia or otherwise authorized to administer topical, local, regional, or general anesthesia by state law or rule; or
  - (iii) Certified Registered Nurse Anesthetist acting under the direction of and in the immediate presence of the operating physician or other physician and who holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by the appropriate licensing board.
- (d) Safety rules to be followed.
- (e) Safety training required of personnel.

- (f) The delineation of pre-anesthesia, intra-operative, and post-anesthesia responsibilities as set forth in the ASC Medical Staff Rules and Regulations and/or other applicable Bylaws, Policies, and Procedures.

#### **5.4. Special Conditions for Podiatric Clinical Privileges**

Requests for Clinical Privileges from Podiatrists shall be processed in the same manner as any other Applicant or Practitioner. Except with respect to Podiatrists who are determined to qualify for (by and through additional training and experience and in a manner consistent with the Medical Staff Rules and Regulations) and receive Clinical Privileges to perform the medical portion of the history and physical, a medical history and physical examination will be made and recorded by a Practitioner who maintains appropriate Clinical Privileges to do so. That Practitioner, and/or another designated Practitioner with appropriate Clinical Privileges, shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of the proposed procedure on the total health status of the patient. The Podiatrist will be responsible for the podiatric care of the patient, including the podiatric history and physical examination. Podiatrists may issue orders within their licensed scope of practice and granted Clinical Privileges, and consistent with applicable Bylaws, Policies, and Procedures.

#### **5.5. Special Conditions for Residents and Fellows**

Residents and fellows in training in the ASC (if ever any) shall not hold Membership on the Medical Staff and/or be granted specified Clinical Privileges. Residents and fellows in training shall be permitted to function clinically in accordance with the written training protocols developed by the MSEC or program director in conjunction with the then current residency training program (if any).

Residents or fellows with a medical license and who intend to practice independently in the ASC, and who meet all other conditions/requirements for Medical Staff Membership and Clinical Privileges, shall be required to apply for and receive appropriate Medical Staff Membership and Clinical Privileges pursuant to the procedures set forth, and subject to all requirements, limitations, and processes, set forth in the Bylaws, Policies, and Procedures.

#### **5.6. Special Conditions for Non-Physician Practitioners and Dependent Professionals**

##### **5.6.1. Credentialing/Supervision**

- (a) As set forth above, APPs shall be evaluated and credentialed through the Medical Staff credentialing process set forth in the Medical Staff Bylaws. AHPAHs shall not be evaluated and credentialed through the Medical Staff Credentialing Processes set forth in this Manual, but instead shall be evaluated and credentialed through the ASC's Human Resources Section and/or other appropriate ASC office pursuant to the ASC's Policies and Procedures.
- (b) APPs may only exercise Clinical Privileges on the condition that they are/remain employees or contractors of the ASC or Orthopaedics Northeast, P.C., or alternatively, are supervised by or formally collaborate with a

designated supervising or collaborative Physician Member of the Medical Staff (to the extent such supervision or collaboration is required by the APP's lawful scope of practice and/or by the Bylaws, Policies, and Procedures). All such APPs must provide evidence, when required, of a current collaborative, supervisory, or employment agreement (as applicable) with a Physician Member of the Medical Staff. APPs may, subject to any licensure requirements or other limitations, exercise independent judgment only within their scope of practice, areas of professional competence, granted Clinical Privileges, and to the extent permitted by the Bylaws, Policies, and Procedures.

- (c) AHPAHPs must be employed or contracted by the ASC or Orthopaedics Northeast, P.C. AHPs may only render professional services under the direct supervision of the Employing Physician Member of the Medical Staff.

### **5.6.2. Automatic Suspension/Termination**

In addition to those applicable administrative remedies and actions set forth in the Corrective Action and Fair Hearing Manual, the following shall apply:

- (a) The Clinical Privileges and/or credentials of an APP or AHP (as applicable) shall administratively terminate, effective immediately and without recourse to any procedural rights set forth elsewhere in the Medical Staff Bylaws, in the event that the APP's or AHP's employment by, or professional services contract (directly or through an affiliated entity) with the ASC, or Orthopaedics Northeast, P.C., or Employing Physician (as applicable) terminates for any reason.
- (b) The Clinical Privileges and/or credentials of an APP or AHP (as applicable) shall administratively suspend, effective immediately and without recourse to any procedural rights set forth elsewhere in the Medical Staff Bylaws, in the event that a required supervisory or collaborative agreement with a Member of the Medical Staff is terminated for any reason. The APP or AHP shall be permitted a period of thirty (30) days, commencing on the date the supervisory or collaborative agreement (as applicable) terminates, to enter into a new or alternate supervisory or collaborative agreement (as applicable and required by law) with another qualified Member of the Medical Staff. If the APP or AHP fails to enter into a new or alternate, legally valid, supervisory or collaborative agreement (as applicable and required by law) prior to the expiration of thirty (30) days, then the suspension shall be automatically converted to a termination of Clinical Privileges and/or credentials (as applicable). Such termination shall constitute an Administrative Action, and thus, shall be without recourse to any procedural rights set forth elsewhere in the Medical Staff Bylaws.

### **5.6.3. Responsibilities of Employing or Collaborative/Supervising Member**

- (a) The number of APPs or AHPAHPs acting as employees/contractors of and/or under the collaboration/supervision of one (1) Member of the Medical Staff, as applicable, as well as the actions that the APP(s) or AHP(s) may undertake, shall be consistent with applicable Law, as well as all applicable Bylaws, Policies, and Procedures.
- (b) It shall be the responsibility of the collaborating or supervising Member of the Medical Staff to countersign medical record entries made by the APPAHP as required by applicable Bylaws, Policies, and Procedures, and/or applicable federal and state law
- (c) APPs and AHPAHPs must maintain professional liability insurance in such form and amounts as required by the Governing Board to cover any and all activities of the APP or AHP at the ASC, and further, must furnish evidence of such coverage to the ASC. An APP shall exercise Clinical Privileges only while such coverage is in effect.

### **5.6.4. Employed APPs and AHPAHPs**

- (a) Except as provided in paragraph (b) immediately below, the employment of an APP or AHP by the ASC or Orthopaedics Northeast, P.C. shall be governed by the employment policies and the terms of the individual's employment relationship.
- (b) If concerns or complaints about an employed APP's clinical competence or professional conduct originates with the Medical Staff, the concern may be reviewed and addressed in accordance with the pertinent provisions set forth in the Corrective Action and Fair Hearing Manual. However, nothing in these Medical Staff Bylaws shall interfere with or impact the rights of the ASC or Orthopaedics Northeast, P.C., to address matters through employment or contractual relationship, as applicable.

## **5.7. Telemedicine Clinical Privileges**

### **5.7.1. Appointment to Medical Staff**

Applicants seeking appointment to the Medical Staff and/or Clinical Privileges to perform telemedicine services may, but need not, be processed pursuant to the complete appointment and privileging procedures described above. Further, such Applicants may be exempted by the MSEC from particular Medical Staff requirements/obligations that are not applicable by virtue of the Applicant's distant site practice (including but not limited to vaccination requirements, meeting attendance requirements, and other such requirements/obligations). Subject to the conditions specified below, Applicants who intend to provide telemedicine services under a written agreement between the ASC and a distant-site hospital or entity, the MSEC may make recommendations to the Governing Board regarding such Applicants

in reliance upon the credentialing and privileging decision of the distant-site hospital or entity with whom the ASC has an agreement for telemedicine services.

#### **5.7.2. Applicants from Distant-Site ASCs or Telemedicine Entities**

Applicants based at distant-site hospitals or entities who intend to provide telemedicine services under a written agreement with the ASC may apply for such telemedicine Clinical Privileges and appointment to the Affiliate Staff provided each Applicant meets the basic qualifications for appointment set forth above and by submission of the same application or application with equivalent content as specified above. Determinations regarding equivalent content will be made by the MSEC, subject to Governing Board approval.

#### **5.7.3. Credentialing of Applicants from Distant-Site ASCs or Telemedicine Entities**

Upon confirmation by the Medical Staff Office that an Applicant's request for appointment and telemedicine Clinical Privileges complies with the terms of the written agreement between the ASC and the distant-site hospital or entity, including Clinical Privileges criteria adopted by the Medical Staff, the MSEC may rely upon the credentialing and privileging decisions made by a distant-site hospital or telemedicine entity when making its recommendation for appointment and Clinical Privileges provided the Agreement between the ASC and distant-site hospital or telemedicine entity (minimally) ensures the following:

- (a) The distant-site hospital is a Medicare participating hospital or the distant-site telemedicine entity provides written assurances that its credentialing and privileging process and standards meet the Medicare Conditions of Participation for ASCs;
- (b) The distant-site hospital or distant-site telemedicine entity, as applicable, meets all other pertinent accreditation requirements to which the ASC may be subject;
- (c) The Applicant/Member is privileged at the distant-site hospital or distant-site telemedicine entity and a current list of equivalent privileges is provided;
- (d) The Applicant/Member holds a current license issued or recognized by the State of Indiana, and complies with any Indiana-specific certification/registration requirements;
- (e) The Applicant/Member meets the professional liability insurance requirements established by the Governing Board; and
- (f) That upon being granted Membership and/or Clinical Privileges, the ASC provides the distant-site hospital or entity evidence of an internal review of the Practitioner's clinical performance for use in the Practitioner's periodic appraisal and, at a minimum, the information must include all adverse events

resulting from the telemedicine services provided by the distant-site Practitioner as well as any registered complaints.

#### **5.7.4. Failure to Utilize Clinical Privileges**

If a Practitioner who has been granted Clinical Privileges to provide telemedicine services at the ASC fails to utilize such Clinical Privileges or otherwise provide telemedicine services to ASC patients at a satisfactory volume as set forth in the Bylaws, Policies, and Procedures (if addressed/applicable) for the purpose of reliably assessing the quality and performance of the Practitioner's telemedicine services, the Practitioner shall be deemed to have voluntarily withdrawn his or her Medical Staff Membership and/or Clinical Privileges, as applicable, effective either six (6) months following the date Practitioner last provided telemedicine services at the ASC or when otherwise acknowledged by the Medical Staff. Such voluntary withdrawal shall constitute an Administrative Action.

#### **5.7.5. Temporary Clinical Privileges for Telemedicine Applicants**

If the ASC has not entered into a written agreement for telemedicine services with a distant-site hospital or entity but has a pressing clinical need for telemedicine services and a distant-site Applicant can supply such services via a telemedicine link, the ASC may evaluate the use of temporary Clinical Privileges for a distant-site Applicant as addressed in Section 5.7 below. In such cases, the distant-site Practitioner must be credentialed and privileged to provide telemedicine services in accordance with ASC standards and procedures applicable to the approved telemedicine services.

#### **5.7.6. Telemedicine Practice**

Clinical practice through telemedicine link is at all times subject to the approval of the ASC and Medical Staff. Further, such practice, when permitted, shall be subject to all applicable ASC and Medical Staff Bylaws, Rules, Regulations, Policies, and Procedures.

### **5.8. Emergency Clinical Privileges**

For the purpose of this Section, an "emergency" is defined as a condition in which serious or permanent harm would result to a patient or bystander or in which the life of a patient or bystander is in immediate danger and any delay in administering treatment would add to that danger. In the case of an emergency, any Practitioner shall be permitted and assisted to do everything possible (within the scope of the Practitioner's license) to save the life of a patient or prevent serious harm, using every facility of the ASC necessary, including the calling of any consultation necessary or desirable, regardless of his or her Medical Staff status or Clinical Privileges. The Practitioner shall make every reasonable effort to communicate promptly with the appropriate individuals concerning the need for emergency care and assistance by Members of the Medical Staff with appropriate Clinical Privileges, shall promptly yield such care to qualified Members of the Medical Staff when it becomes reasonably available, and once the emergency has passed or assistance has been made available, shall defer to the

Medical Staff President, in consultation with the Medical Director, with respect to further care of the patient.

## **5.9. Disaster Clinical Privileges**

### **5.9.1. Circumstances**

Any individual intending to provide services during a disaster event must be granted Clinical Privileges prior to providing patient care. Disaster privileges are considered temporary in nature.

### **5.9.2. Conditions**

- (a) The COO, Medical Director, or Medical Staff President, or their respective designees, in circumstances of disaster in which the ASC's emergency operation plan has been activated, shall have the authority to grant disaster privileges to a Physician, Podiatrist, or APP who is not a Member of the Medical Staff, or otherwise Clinically Privileged, as applicable, subject to the process and conditions set forth in this Section.
- (b) Decisions regarding the granting of disaster privileges are made on a case-by-case basis. The COO, Medical Director, and Medical Staff President, or their respective designees, are not required to grant Clinical Privileges to any individual. Prior to granting such Clinical Privileges, the COO, Medical Director, or Medical Staff President, or their designee, shall verify information regarding the individual upon presentation of a valid government issued photo identification card and at least one (1) of the following:
  - (i) A current picture identification card from a health care organization that identifies the Practitioner's professional designation;
  - (ii) A current license to practice;
  - (iii) Primary source verification of licensure;
  - (iv) Identification indicating that the individual is a Member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group;
  - (v) Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal entity; or
  - (vi) Confirmation by a Practitioner who is currently privileged by the ASC with personal knowledge regarding the Practitioner's ability to act as a licensed independent Practitioner during a disaster.

- (c) Primary source verification of licensure, certification, or registration (if required by Law in order to practice), as well as verification of credentials under these Medical Staff Bylaws for granting temporary Clinical Privileges, shall begin as soon as the disaster is under control, but no later than seventy-two (72) hours. In extraordinary circumstances, primary source verification and/or evaluation for temporary Clinical Privileges of credentials may occur later than seventy-two (72) hours and as soon as possible. In such case, the ASC shall document the reasons for any delay, evidence of the health care provider's demonstrated ability to continue to adequate care, treatment and services and evidence of the ASC's attempt to perform credentialing verification in a timely manner.
- (d) The MSEC or designee will oversee the performance of individuals granted disaster privileges by either direct observation, mentoring or medical record review as may be more fully described in the ASC's emergency operation plan.
- (e) The COO, or designee, in consultation with the Medical Staff President and/or Medical Director, will determine within seventy-two (72) hours of each Practitioner's arrival whether granted disaster privileges should continue.

#### **5.10. History and Physical Examination Requirements**

A medical history and physical examination, which is signed or cosigned by a Physician, must be completed by a Practitioner with requisite Clinical Privileges in-person and documented for each patient in accordance with the Bylaws, Policies, and Procedures, and as required by Law. In all instances, a history and physical exam must be performed and documented within thirty (30) days prior to date of admission or within twenty-four (24) hours after an admission. If a history and physical is performed and documented prior to the date of admission, then a thorough updating entry must be provided within twenty-four (24) hours after the admission, which documents/addresses vital signs, systems stability, any systems or other relevant change, and any other information pertinent to the admission. With respect to surgical patients, in all such cases there must be a history and physical workup in the chart prior to surgery, except in emergencies. If the report has been dictated, but not yet recorded in the patient's chart, there shall be a statement to that effect and an admission note in the chart by the admitting Physician, which includes vital signs, allergies, and appropriate data.

The content of complete and focused History and Physical examinations is delineated in the Medical Staff Rules and Regulations and applicable Medical Record Completion policies.

#### **5.11. Impaired Member or APP**

- (a) An impaired Practitioner is one who is unable to render professional services with reasonable skill and safety to patients due to a physical or mental illness or condition, whether caused by cognitive decline, loss of motor skills, the excessive use or abuse of drugs, including but not limited to alcohol, or other problems affecting his or her ability to practice effectively and/or safely. The Medical Staff requires that all Practitioners who are granted Clinical Privileges

be and remain able to: exercise such Clinical Privileges, engage in professional practice, and participate in ASC and Medical Staff related functions and events without impairment. All Practitioners agree, as a condition of ongoing Medical Staff Membership and/or Clinical Privileges (as applicable), to such requirements, and further, agree to abide by all Bylaws, Policies, and Procedures, as well as the MSEC's authority, in relation to addressing potential Practitioner impairment. All Practitioners additionally agree, as a condition of ongoing Medical Staff Membership and/or Clinical Privileges (as applicable), to **confidentially and promptly** self-report and to otherwise report (as applicable) impairment concerns pursuant to the Bylaws, Policies, and Procedures.

- (b) Any questions or concerns in relation to applicable policies or procedures should be directed to the COO, Medical Staff President, Medical Director, or any member of the MSEC. At the discretion of the COO, impairment concerns related to employed Practitioners may be addressed pursuant to the ASC's human resources policies for individuals employed by the ASC and for individuals who work for a group under contract with the ASC.
- (c) The MSEC, as well as any/all other pertinent Medical Staff committees, will address Practitioner impairment matters in a confidential, unbiased manner while striving to protect patient safety and the rights of the applicable Practitioner. Notwithstanding anything in the Bylaws, Policies, and Procedures to the contrary, for clarity, the MSEC is under no obligation to evaluate or treat an impaired Practitioner, as this is an obligation of the Practitioner's personal physician or other health care providers. The MSEC, in its discretion, may rely upon evaluations and assessments by the Practitioner's providers and/or independent practitioners to determine whether a Practitioner is safe to practice. This determination may involve establishing conditions that the Practitioner must meet to continue practicing, which may include, but are not limited to: random drug screens, regular appointments with a psychologist, psychiatrist or other appropriate health care provider; imaging, laboratory or other diagnostic studies; proof of attendance at treatment related meetings; and/or a conditional leave of absence. If there is sufficient evidence supporting impairment and if a Practitioner fails to satisfy any conditions imposed by the MSEC, or if quality of care or patient safety are at risk, a Practitioner's Membership and/or Clinical Privileges (as applicable) may be suspended pending further investigation and potential action in accordance with the Corrective Action and Fair Hearing Manual.

#### **5.12. Focused and Ongoing Professional Practice Evaluation**

As part of its ongoing quality improvement activities, and in compliance with Law, the ASC engages in both Focused and Ongoing Professional Practice Evaluation.

- (a) Focused Professional Practice Evaluation (“FPPE”) at the ASC is intended to serve two purposes:

- (i) The Peer Review evaluation, for privilege-specific competency, of (a) new Practitioners at the ASC seeking Clinical Privileges and of (b) current Practitioners at the ASC that have requested to receive new or additional Clinical Privileges (this type of FPPE is also referred to in the Bylaws, Policies, and Procedures as “Professional Practice Evaluation” or “PPE”); and
  - (ii) The Peer Review evaluation of Practitioners at the ASC where specific performance related concerns implicating patient safety and/or quality of care are identified.
- (b) Ongoing Professional Practice Evaluation (“OPPE”) is a systematic and ongoing Peer Review process used to evaluate and confirm the current competency of those Practitioners with Clinical Privileges at the ASC. OPPE is intended to assist the Medical Staff with identifying and resolving Practitioner related performance concerns or trends that may adversely impact patient safety or quality of care. OPPE is intended to foster an efficient, evidence-based privilege monitoring and renewal process. Information generated through OPPE will be used to evaluate the qualifications of Practitioners, including determinations to continue, limit, or revoke any existing privileges(s). Information generated through OPPE, within the requirements of Peer Review confidentiality, will also be utilized for more systematic performance improvement activities intended to maintain or improve patient safety and quality of care.

The ASC’s process for OPPE and FPPE will be facilitated through regular Peer Review meetings and will incorporate periodic review of, but not be limited to, the following:

- (a) Appropriateness of diagnosis and treatments rendered related to a standard of care and anticipated or expected results;
  - (b) Performance evaluation based on clinical performance indicated in part by the results or outcome of surgical intervention; and
  - (c) Scope and frequency of procedures.
- (c) This review and evaluation will occur as part of the ASC’s established Peer Review processes for OPPE and FPPE.

The applicable and detailed policies and processes for FPPE and OPPE, both of which are Peer Review processes, are set forth in applicable ASC policies and procedures.

## **ARTICLE VI**

### **MEDICAL STAFF OFFICERS**

#### **6.1. Medical Staff Officers**

The following Medical Staff Officers shall be Members of the Active Staff who fulfill necessary governance functions of the Medical Staff and who represent the needs and interests of the entire Medical Staff:

- (a) Medical Staff President; and
- (b) Medical Staff President-Elect.

#### **6.2. Qualifications**

Officers must be Members of the Active Staff at the time of nomination and election, and must remain Members of the Active Staff in good standing during their term of office. No Member under consideration for an officer position may be under current investigation by the Medical Staff or have had significant or repeated quality of care or professional conduct issues. Nominees should have a reputation for leadership and excellent patient care services, and be willing to serve in a leadership position. Failure to maintain such status shall immediately result in the Member's disqualification to hold office. Any action taken to remove or disqualify a Member pursuant to this section shall constitute an Administrative Action.

#### **6.3. Nominations**

Nominations for Medical Staff President-Elect may be made by the MSEC and/or by a petition signed by at least five (5) Members of the Active Staff. Any such nominations must be submitted to the current Medical Staff President at least thirty (30) days prior to the Medical Staff Annual Meeting (or Special Meeting if required) where such vote shall occur. The names of these additional nominees shall be transmitted to all Members of the Active Staff at least five (5) days prior to the Annual or Special Meeting where such vote shall occur. In the event no nomination is timely submitted, then the current President of the Medical Staff will call for verbal nominations at the Annual or Special Meeting where the vote is scheduled to occur.

#### **6.4. Succession and Election of Officers**

- (a) The incoming Medical Staff President-Elect shall be elected at the Annual Meeting (or Special Meeting if required) of the Medical Staff by Members of the Active Staff. Voting shall be by secret written or designated electronic ballot, unless the President of the Medical Staff calls for a voice or hand-vote (and no Member expresses an objection to same). A Member of the Active Staff who is eligible to vote, but who cannot be present at the Annual Meeting (or Special Meeting if required), may cast an absentee ballot by designated electronic ballot pursuant to the balloting procedures set forth below with respect to Medical Staff Meetings. Alternatively, in the discretion of the Medical

Staff President, voting may be accomplished by way of subsequent mailed or electronic ballot, as set forth in Section 9.4, below.

- (b) The Medical Staff President-Elect shall, upon completion of his/her term of office in that position, immediately succeed to the office of the Medical Staff President.

## **6.5. Terms**

Each Officer shall serve a two (2) year term, commencing on the first day of the Medical Staff Year following his/her election or appointment (as applicable). Each Officer shall serve until the end of term and/or until a successor is elected, unless he/she shall sooner resign or be removed from office. Nothing herein is intended to preclude a past Officer from being nominated to serve, or serving, as a future Officer if otherwise eligible to serve pursuant to Bylaws, Policies, and Procedures.

## **6.6. Removal**

The MSEC, by a two-thirds vote, may remove any Medical Staff Officer. Alternatively, the Governing Board may remove any Medical Staff Officer. In any event, removal may be based upon the loss of a Member's eligibility to maintain the Office, or by demonstrating a material failure to perform (in the discretion of those groups eligible to initiate removal) any of the duties of the position. The removal of an Officer shall constitute an Administrative Action.

## **6.7. Vacancies**

If there is a vacancy in the Office of Medical Staff President, the Medical Staff President-Elect shall serve out the remaining term. All other vacancies shall be filled by the MSEC if the remaining term is less than six (6) months and by a special election of the Active Staff at its next scheduled meeting (or thereafter by subsequent mailed or electronic ballot in the discretion of the Medical Staff President, as set forth in Section 9.4, below) if the remaining term is greater than six (6) months.

## **6.8. Duties**

### **6.8.1. Medical Staff President**

- (a) The Medical Staff President shall serve as the chief administrative officer of the organized Medical Staff. His or her responsibilities shall be to:
  - (i) Represent the views, policies, needs and grievances of the entire Medical Staff to the Governing Board, COO, and Medical Director;
  - (ii) Work with the COO and Medical Director in all matters of mutual concern within the ASC;
  - (iii) Call, preside at, and be responsible for the agenda of all general and special meetings of the Medical Staff;

- (iv) Serve as Chairperson of the MSEC;
  - (v) Serve as an ex officio Member of all other Medical Staff committees;
  - (vi) Be responsible for the enforcement of the Medical Staff Bylaws, for implementation of corrective action activities and sanctions where indicated, and for the Medical Staff's compliance with the procedural safeguards in all instances where corrective action has been requested against a Practitioner;
  - (vii) Appoint members and chairpersons of each standing, special, and multidisciplinary Medical Staff committee, except as may otherwise be expressly provided in the Bylaws, Policies, and Procedures;
  - (viii) Be responsible, as Chairperson of the MSEC, for carrying out quality assessment and performance improvement functions of the Medical Staff;
  - (ix) Be the spokesperson for the Medical Staff in its external professional and public relations;
  - (x) Authorize expenditures of Medical Staff funds, if applicable, as provided herein; and
  - (xi) Perform such other functions as may be required by the Bylaws, Policies, and Procedures, and/or that may be assigned by the Members, by the MSEC, or by the Governing Board.
- (b) When undertaking these responsibilities, the Medical Staff President is acting at all times on behalf of, and subject to, the MSEC's authority.

**6.8.2. Medical Staff President-Elect**

- (a) He or she shall generally assist the Medical Staff President as may be requested and shall perform such other duties as may be required by the Bylaws, Policies, and Procedures, and/or that may be assigned by the Medical Staff President, by the MSEC, or by the Governing Board.
- (b) In the absence of the Medical Staff President, the Medical Staff President-Elect shall assume all the duties and have the authority of the Medical Staff President.
- (c) He or she shall be a Member of the MSEC and such other Medical Staff committees as may be prescribed by the Bylaws, Policies, and Procedures.

## **6.9. Use of Designees**

Any Medical Staff Officer may delegate certain tasks and activities to various designees, including but not limited to the Medical Director and COO, to assist the Officer in fulfilling his or her duties and responsibilities, which may include activities related to credentialing, privileging, and other such Peer Review activities.

## **ARTICLE VII**

### **STANDING MEDICAL STAFF COMMITTEES**

#### **7.1. Standing Medical Staff committees**

The standing committees of the Medical Staff shall include:

- (a) The Medical Staff Executive Committee;
- (b) All such other Standing Committees that are set forth in the Medical Staff Organizational Plan, which is attached to this manual as Appendix B and which may be updated, as needed, in the discretion of the MSEC.

All standing committees of the Medical Staff are subject to oversight by, and report to, the MSEC.

#### **7.2. Appointment and Term**

Unless otherwise specified in the Bylaws, Policies, and Procedures (including but not limited to those members who serve by virtue of their position): (a) standing Medical Staff committee members and chairpersons will be appointed by the Medical Staff President (b) will serve for a term of one (1) year, commencing on the date specified by the Medical Staff President, (c) may serve successive and concurrent terms, and (d) will continue to serve beyond one (1) year in such position in the event no action has been taken to reappoint, remove, or replace such member.

#### **7.3. Removal and Vacancies**

Unless otherwise provided for in the Bylaws, Policies, and Procedures, the chairperson of a Medical Staff committee, with concurrence of the MSEC, for good cause, may remove any Medical Staff committee member prior to the expiration of the member's term, and may fill such vacancy by appointment.

#### **7.4. Ad Hoc Medical Staff committees**

Unless otherwise provided for in the Bylaws, Policies, and Procedures, Ad Hoc Medical Staff committees, as may be required to carry out activities of the Medical Staff, may also be appointed by the Medical Staff President. Such committees shall be limited to a term as established by the Medical Staff President (as applicable) and shall confine their activities and duration to the purpose for which they were appointed. The Medical Staff President may, at

any time in his/her discretion, remove and/or replace Ad Hoc committee members.

## **7.5. Medical Staff Executive Committee**

### **7.5.1. Composition**

The voting members of the MSEC shall be the following:

- (a) Medical Staff President, who shall serve as the Chairperson;
- (b) Medical Staff President-Elect; and
- (c) One (1) to three (3) additional members who are appointed by the Medical Staff President.

The following individuals shall serve as ex officio members of the MSEC without the right to vote:

- (a) COO (or authorized designee);
- (b) VP Operations of the ASC;
- (c) Medical Director; and
- (d) Nursing Manager of the ASC.

The Chairperson of the MSEC may invite additional guests to MSEC meetings.

### **7.5.2. Duties and Authority**

The duties of the MSEC shall be to:

- (a) Account to the Governing Board and to the Medical Staff for the overall quality and efficiency of professional patient care services provided in the ASC by Practitioners, and coordinate the participation of the Medical Staff in organizational performance improvement activities;
- (b) Serve as the final decision-making body of the Medical Staff in accordance with the Bylaws, Policies, and Procedures and to provide oversight for all Medical Staff functions;
- (c) Represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by the Medical Staff Bylaws;
- (d) Serve as the Medical Staff's credentialing body, and in so doing, investigate, review, evaluate, report on, and make recommendations to the Governing Board regarding the qualifications of each Applicant for initial Medical Staff Membership and/or Clinical Privileges and each Practitioner for

reappointment or modification of appointment to the Medical Staff and/or for Clinical Privileges;

- (e) Undertake primary responsibility for the ongoing and focused review of Practitioners rendering clinical services in the ASC and, when necessary, undertake investigations, administrative actions, and professional review actions as set forth in the Corrective Action and Fair Hearing Manual and as may otherwise be contemplated by the Bylaws, Policies, and Procedures;
- (f) Recommend, establish, and implement, within its granted authority, policies and procedures to ensure that the needs and concerns expressed by Members of the Medical Staff, regardless of practice or location, are given due consideration.
- (g) Coordinate the activities of, and review and act on Medical Staff policies, procedures, and recommendations of other Medical Staff committees and Medical Staff Members, as applicable;
- (h) Take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of Practitioners, including collegial and educational efforts and investigations when warranted;
- (i) Make recommendations to the COO and Governing Board on medico-administrative and ASC management affairs, including patient care needs such as space, staff, and equipment;
- (j) Educate the Medical Staff regarding the licensure and accreditation status of the ASC;
- (k) Act upon the recommendations of the Governing Board;
- (l) Consider, adopt and implement various policies and procedures as may be necessary to fulfill and enforce the general provisions of the Bylaws, Policies, and Procedures and the Medical Staff's overall functions and obligations;
- (m) Serve as the Medical Staff's Medical Staff Bylaws review committee, and in so doing, review the Bylaws at least on a triennial basis and recommend any amendments determined to be necessary or otherwise appropriate;
- (n) Act on behalf of the Medical Staff when the Medical Staff cannot be assembled, or between regular meetings of the Medical Staff; and
- (o) Fulfill those other functions designated for the MSEC as set forth in the Bylaws, Policies, and Procedures and as otherwise may be required by Law.

Notwithstanding the establishment of any Peer Review policies for implementation of various quality assurance and performance improvement activities within the ASC, the

MSEC and Governing Board retain the authority at all times to undertake such Peer Review activities that they deem appropriate under the circumstances.

### **7.5.3. Regular Meetings**

The MSEC shall generally meet on a monthly basis, but in all instances will meet as frequently as needed to fulfill its functions. Regular meetings will occur at such dates, times, and places as are designated by the Medical Staff President or designee. Written or electronic notice stating the date, time, and place of any regular meeting shall be given to each member of the MSEC at least thirty (30) days when reasonably possible.

### **7.5.4. Special Meetings**

A special meeting of the MSEC may be called by the Medical Staff President or designee, or by one-third (1/3) of the MSEC's voting members. Written, electronic, or personal verbal notice to the members stating the date, time and place of any special meeting shall be given to each member of the MSEC at least forty-eight (48) hours in advance of the special meeting, or otherwise as soon as reasonably practicable before the time of such meeting.

### **7.5.5. Quorum/Action**

A quorum at any regular or special meeting of the MSEC shall be at least fifty percent (50%) of the voting members. When permitted by the Medical Staff President or designee, committee action may additionally occur by mail or electronic ballot, as long as a ballot reciting the issue or resolution to be voted upon is distributed to each committee member eligible to vote and the member is provided at least five (5) days (following the date the ballot is distributed) to consider and return the ballot by the prescribed method (unless a quorum of the committee agrees that circumstances reasonably require a more prompt response). In order for the results of a mail or electronic ballot to be binding, a majority of the votes received shall be in favor thereof.

### **7.5.6. Attendance Requirements**

- (a) Members of the MSEC are expected to regularly attend meetings, but in all instances, are expected to attend at least fifty percent (50%) of regular meetings. Exceptions may be made by the Medical Staff President for good cause in his/her discretion. Failure to comply with this attendance requirement may constitute a good cause basis to remove a member from his/her underlying appointment giving rise to his/her membership on MSEC, subject to the requirements for such removal specific to the underlying appointment.
- (b) In the discretion of the Medical Staff President or designee, a committee may meet, or may permit any of their members to participate, in person, or by video or telephonic means such that the committee members may simultaneously interact and participate in the meeting. Notwithstanding the

foregoing, when matters involving Peer Review will be discussed, in-person meetings are encouraged but are not strictly required.

#### **7.5.7. Minutes**

Minutes of each regular and special meeting of the MSEC shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the Medical Staff President as soon as reasonably practicable after they are prepared. The MSEC will maintain a permanent file of the minutes of each meeting. Minutes taken pertinent to executive sessions may be maintained, in the discretion of the Medical Staff President, in a separate permanent file.

#### **7.5.8. Executive Session**

The Chairperson, or at least fifty percent (50%) of the members of the MSEC present at a meeting, may call for an Executive Session, at which time only voting members and those ex officio members expressly invited, may attend. All Peer Review matters should be conducted in executive session. An executive session may additionally be called to discuss personnel issues or any other sensitive issues requiring heightened confidentiality.

#### **7.5.9. Term, Removal, and Vacancies**

The members of the MSEC serve by virtue of their office or other appointment, and shall therefore serve for the duration of their office or appointment. In the event such member is removed from, or otherwise vacates, his or her underlying appointment in accordance with the Medical Staff Bylaws, that member shall automatically lose his/her membership on the MSEC. Such positions shall remain vacant until the underlying appointment is filled in a manner (including interim appointments) as set forth in the Medical Staff Bylaws.

### **ARTICLE VIII**

#### **MEDICAL STAFF MEETINGS**

##### **8.1. Regular Meeting**

The Medical Staff shall generally meet on a quarterly basis. At least one of these meetings (typically the final regular meeting of the Medical Staff Year) shall serve as the Annual Meeting of the Medical Staff, at which time Active Members may conduct any pertinent Medical Staff elections and may address any other pertinent issues as established by the Medical Staff President. The date, time, place, and manner of the Medical Staff meeting(s) shall be designated by the Medical Staff President and either posted in an appropriate location in the Hospital, or otherwise provided electronically or by regular mail to the eligible Members of the Medical Staff, not less than thirty (30) days prior to the meeting.

## **8.2. Special Meetings**

The Medical Staff President or the MSEC may call a special meeting of the Medical Staff at any time. The Medical Staff President shall additionally call a special meeting within fourteen (14) days after receipt by him or her of a written request signed by not less than twenty-five percent (25%) of those Members eligible to participate and vote at such meetings, and stating the purpose of such meeting. The Medical Staff President or MSEC (whoever called for the special meeting) shall designate the date, time and place of any special meeting. Written or electronic notice stating the date, time, and place of any special meeting of the Medical Staff shall be given to Members eligible to participate and vote at such meetings.

## **8.3. Quorum/Attendance**

A quorum at any duly convened regular or special meeting of the Medical Staff shall be the in-person or virtual (when permitted) presence of at least 50% of the eligible voting Members. In-person attendance is encouraged at all Medical Staff meetings. However, the Medical Staff President may permit virtual attendance by Medical Staff Members at a regular or special meeting. Virtual attendance may be conducted through the use of any means of communication by which all attendees may simultaneously hear each other during the meeting. Notwithstanding the foregoing, when matters involving Peer Review will be discussed, in-person meetings are encouraged and should be conducted when reasonably possible under the circumstances. Members are expected to regularly attend Medical Staff meetings, but in all instances, are expected to attend at least fifty percent (50%) of regular meetings. Exceptions may be made by the Medical Staff President for good cause in his/her discretion. Failure to comply with this attendance requirement may otherwise constitute a good cause basis to remove a Member from his/her underlying appointment to the Active Staff.

## **8.4. Action**

An action will be approved if a majority of those attending and eligible at a meeting at which a quorum exists votes to support the action. When permitted by the Medical Staff President, and notwithstanding anything herein to the contrary, action may alternatively occur by mail or electronic ballot, as long as a ballot reciting the issue or resolution to be voted upon is distributed to each Member eligible to vote and the Member is provided at least fifteen (15) days (following the date the ballot is distributed) to consider and return the ballot by the prescribed method. In order for the results of a mail or electronic ballot to be binding, a majority of the votes received shall be in favor thereof.

## **8.5. Minutes**

Minutes of all Medical Staff meetings shall be taken and prepared by the Medical Staff President, or his/her designee, and shall include a record of attendance and/or the presence of quorum and the vote taken on each matter. Copies of such minutes shall be signed by the Medical Staff President as soon as practicable after they are prepared and shall be forwarded to the Governing Board. These minutes shall be deemed final when transmitted to the Governing Board, subject, however, to such corrections as may be made at the next regular

or special meeting of the Medical Staff. A permanent file of the minutes of all Medical Staff meetings shall be maintained by Medical Staff Office.

## **ARTICLE IX**

### **MEDICAL STAFF COMMITTEE MEETINGS**

Unless otherwise set forth in the Bylaws, Policies, and Procedures, the following shall apply to, and serve as default requirements of, all standing and ad hoc committees of the Medical Staff:

#### **9.1. Regular Meetings**

Medical Staff committees shall meet as often as necessary to fulfill their responsibilities and at such dates, times, and places as are designated by the chairperson of the committee. Written or electronic notice stating the date, time, and place of any regular meeting shall be given to each member of the committee.

#### **9.2. Special Meetings**

A special meeting of any Medical Staff committee may be called by the chairperson, the Medical Staff President, or one-third (1/3) of the committee's then members (but not fewer than two (2) members). Written, oral or electronic notice stating the date, time and place of any special meeting shall be given to each committee member as soon as practicable before the time of such meeting, unless waiver of notice is agreed to by all members of the committee.

#### **9.3. Quorum**

A quorum shall consist of those attending and eligible to vote, provided no fewer than two (2) voting Members are in attendance.

#### **9.4. Manner of Action/Balloting Procedure**

An action by a committee will be approved if a majority of those attending and eligible at a meeting at which a quorum exists votes to support the action. When permitted by the chairperson, committee action may alternatively occur by mail or electronic ballot, as long as a ballot reciting the issue or resolution to be voted upon is distributed to each committee member eligible to vote and the member is provided at least five (5) days (following the date the ballot is distributed) to consider and return the ballot by the prescribed method (unless a quorum of the committee agrees that circumstances reasonably require a more prompt response). In order for the results of a mail or electronic ballot to be binding, a majority of the votes received shall be in favor thereof.

#### **9.5. Rights of Ex Officio Members**

Ex officio members of a committee shall have all rights and privileges of regular members, except that ex officio members shall not have the right to vote and shall not be counted in determining the existence of a quorum.

## **9.6. Attendance**

In the discretion of the chairperson, a committee may meet, or may permit any of their members to participate, in person, or by video or telephonic means such that the committee members may simultaneously interact and participate in the meeting. Regular attendance by members at meetings is expected. Notwithstanding the foregoing, when matters involving Peer Review will be discussed, in-person meetings are encouraged and should be conducted when reasonably possible under the circumstances.

## **9.7. Record/Minutes**

Minutes or other reliable record of each regular and special meeting of a committee shall be prepared and shall identify which members were in attendance and any action taken. The chairperson shall sign such record/minutes, which shall be maintained in an appropriate file and made available to the MSEC.

## **9.8. Executive Session**

An executive session is a meeting of a committee at which only Medical Staff members who are voting members of the committee are permitted to attend, unless other individuals are expressly requested by the chairperson or committee. Executive sessions may be called by the chairperson at the request of any committee member, and shall be called by the chairperson by duly adopted motion. An executive session may be called to discuss Peer Review issues, personnel issues, or any other sensitive issues requiring confidentiality. The Medical Staff President shall be an invited guest at all executive sessions.

## **9.9. Use of Designees**

Any committee may delegate certain tasks and activities to various designees, whether a committee or individuals, including the Medical Staff President, COO, Medical Director, or other ASC personnel, to assist the committee in fulfilling its duties and responsibilities, which may include activities related to credentialing, privileging, and other Peer Review activities.

## **ARTICLE X**

### **CONFIDENTIALITY, IMMUNITY AND RELEASES**

#### **10.1. Authorizations and Conditions**

- (a) By applying for or exercising Medical Staff Membership and/or Clinical Privileges or by providing specified patient care services at this ASC, each Applicant and Practitioner specifically authorizes the System, ASC, and Medical Staff, and their authorized representatives and designees, to consult with any third party who may have information bearing on the Applicant's or Practitioner's professional qualifications, credentials, clinical competence, character, mental and physical condition, ethics, behavior, or any other matter related to the delivery of quality patient care.

- (b) This authorization also covers the right to inspect or obtain any and all communications, reports, records, statements, documents, recommendations, or disclosures of all third parties that may be relevant to the Medical Staff and Governing Board's review, and each Applicant and Practitioner specifically authorizes all third parties to release and provide such information to the ASC, Medical Staff, and their authorized representatives upon request, and further:
  - (i) Authorizes Medical Staff and ASC representatives to solicit, release, provide, disclose, and act upon information bearing on his or her competence, professional conduct, qualifications, patient care, and quality outcomes to health care entities and their agents, including resources and entities used by the System and ASC for internal quality control, reducing morbidity and mortality, and improving patient care;
  - (ii) Agrees to be bound by the provisions of this Article and to waive all legal claims against the System, ASC, Medical Staff and any Medical Staff or ASC representative or designee who acts in substantial compliance with the Bylaws, Policies, and Procedures;
  - (iii) Acknowledges that the provisions of this Article are express conditions to his or her application for or acceptance of Medical Staff Membership and/or the continuation of such Membership or to his or her exercise of Clinical Privileges at the ASC; and
  - (iv) Acknowledges and consents to the System, ASC, and Medical Staff providing any communications required or contemplated by the Medical Staff Bylaws, or otherwise deemed reasonably necessary by the ASC or Medical Staff, by way of the email address provided by the Applicant or Practitioner to the Medical Staff Office. All Applicants and Practitioners further represent, warrant and agree that the email address they provide to the Medical Staff Office is accurate, current, private, and secure.

## **10.2. Confidentiality of Information**

Information with respect to any Applicant or Practitioner that is submitted, collected, obtained or prepared by any System, ASC, or Medical Staff or Peer Review Committee, or member, representative or designee of such committee, or any other health care facility or organization or Medical Staff for the purpose of achieving, maintaining and improving quality patient care, reducing morbidity and mortality, contributing to clinical research or performing any Peer Review or Peer Review Committee activity, shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than an appropriate System, ASC, or Medical Staff representative, nor be used in any way except as provided herein or except as otherwise permitted by the Bylaws, Policies, and Procedures and by Law. Such confidentiality shall also extend to similar information that may be obtained from or provided

by third parties. This confidentiality of information shall not be construed to limit the authorizations set forth in Section 10.1 above.

### **10.3. Immunity From Liability**

There shall be, to the fullest extent permitted by law, absolute immunity from civil liability arising from any act, communication, report, recommendation, or disclosure contemplated by the Bylaws, Policies, and Procedures, even where the information involved would otherwise be deemed privileged. To the fullest extent permitted by law, all individuals requesting an application, and Applicants and Practitioners requesting and/or maintaining Medical Staff Membership and/or Clinical Privileges, or any individual seeking to provide or providing patient care services in the ASC, releases from any and all liability, extends absolute immunity and agrees not to sue, to the System, ASC, the Medical Staff, their authorized representatives, and any third party, for any actions, omissions, communications, requests, reports, records, statements, documents, recommendations, or disclosures involving the individual, or requested, sent or received by the System, ASC, or the Medical Staff, and their authorized representatives and designees, from or to any third party in furtherance of quality health care. The acts, communications, reports, recommendations and disclosures referred to in this Article may relate to an individual's professional qualifications, clinical competency, professional conduct, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

### **10.4. Activities and Information Covered**

The confidentiality and immunity provided by this Article shall apply to all actions, information, communications, reports, recommendations or disclosures performed or made in connection with activities of the System, ASC, and Medical Staff concerning, but not limited to:

- (a) Applications for Membership, Clinical Privileges, or other specified services;
- (b) Periodic reappraisals for reappointment, Clinical Privileges or specified services;
- (c) Patient care audits;
- (d) Utilization reviews;
- (e) FPPE and OPPE;
- (f) Corrective action;
- (g) Hearings and appellate procedures;
- (h) Any Peer Review or Peer Review Committee activity;
- (i) Reports or disclosures to the National Practitioner Data Bank, other hospitals, medical staffs, medical associations, and licensing boards;

- (j) System-wide quality improvement activities; and
- (k) Any information collected and/or reported to a Patient Safety Organization in which the System or ASC participate.

#### **10.5. Releases**

Each Applicant and Practitioner shall additionally, upon request, execute any general or specific release as part and a condition of the Membership and/or Clinical Privileging process. Refusal or failure to execute, and thus further document, such releases, however, shall in no way affect the immunity release and consents made by the Applicant or Practitioner, as described above, which are express conditions of seeking, obtaining, and/or maintaining Medical Staff Membership and/or Clinical Privileges.

#### **10.6. Indemnification**

All Medical Staff Officers, Chairpersons, Committee members, Practitioners and other individuals who are appropriately authorized by the MSEC or Governing Board to act for and on behalf of the System or ASC in performing functions pursuant to these Medical Staff Bylaws shall be indemnified when acting in those capacities to the fullest extent permitted by the Bylaws, Policies, and Procedures, provided that such individuals have acted in good faith, without malice, and in the best interest of the System, ASC, and Medical Staff.

#### **10.7. HIPAA Compliance/Organized Health Care Arrangement**

- (a) As applicable, and in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the Medical Staff and ASC agree to operate as an Organized Health Care Arrangement (OHCA) under which a joint notice of privacy practices is issued, and the participating entities in the OHCA share protected health information with each other, as necessary to carry out treatment, payment, and health care operations related to activities of OHCA, such as quality assurance activities. In such case, the entities participating in the OHCA agree to abide by the terms of the joint notice with respect to protected health information created or received by a covered entity as part of its participation in the OHCA. The joint notice is written, disseminated and maintained in compliance with all applicable regulatory requirements, as outlined in the HIPAA implementing regulations.
- (b) Under the OHCA, the Medical Staff and ASC, as participants in the OHCA, separately retain all other obligations and responsibilities under the HIPAA regulations, including, but not limited to, the uses and disclosures of protected health information, fulfilling the patient rights provisions and appointment of a privacy officer. Additionally, individual Members of the Medical Staff and ASC will retain individual liability for instances of non-compliance with the HIPAA regulations.

## **10.8. Reporting to Authorities**

Any actions that occur as a result of or in relation to an Applicant or Practitioner that are reportable to the National Practitioner Data Bank and/or to any other pertinent state licensing board or other agency, as required or permitted by applicable state and federal law, shall be reported in the manner and time period required or permitted by such authorities.

## **10.9. Cumulative Effect**

Provisions in these Medical Staff Bylaws and in application forms relating to authorizations, confidentiality of information and immunity from liability shall be in addition to other protections afforded by applicable state and federal laws and not in limitation thereof, and in the event of conflict, applicable law shall be controlling.

## **ARTICLE XI**

### **EXCLUSIVE CONTRACTS, SERVICES, CLOSURE**

As part of the ongoing process for evaluation and planning of patient care services, in the furtherance of quality patient care, the Governing Board may determine, in consultation with the MSEC, that particular patient care service(s) or Clinical Privilege(s) should be implemented on an exclusive basis, pursuant to an exclusive agreement, closed, or discontinued. In the event that staffing of a patient care service or Clinical Privilege is limited or modified as referenced above, then the Membership and Clinical Privileges of impacted Practitioners, in the discretion of the Governing Board, shall be modified accordingly and/or considered a voluntary relinquishment of Medical Staff Membership and Clinical Privileges. This voluntary relinquishment, and the Governing Board's determination in connection with this Section, shall constitute an Administrative Action.

## **ARTICLE XII**

### **MEDICAL STAFF DOCUMENTS**

#### **12.1. Adoption of Related Documents**

In addition to this Governance and Credentialing Manual, the Medical Staff and Governing Board have adopted the Medical Staff Corrective Action and Fair Hearing Manual. These two manuals, collectively, comprise the Medical Staff Bylaws.

#### **12.2. Medical Staff Bylaws are NOT a Contract**

The Medical Staff Bylaws are intended to create a framework to ensure compliance with pertinent State and Federal law, and accreditation requirements, and to ensure entitlement to all immunities and protections set forth in the pertinent State peer review statutes and the Federal Health Care Quality Improvement Act. These Bylaws are not intended in any fashion to create a legal contract. Accordingly, these Bylaws shall not be interpreted as, nor construed to be, a contract of any kind between the ASC and the Medical Staff as a whole, or any individual Applicant or Practitioner individually, and shall not in any fashion give rise to any type of legal action, claim or proceeding for breach of contract.

### **12.3. Rules and Regulations**

The MSEC shall have the authority of the Medical Staff to adopt and amend the Medical Staff Rules and Regulations as may be necessary to carry out the Medical Staff's functions. Any changes to the Rules and Regulations shall become effective when approved by the Governing Board. All Rules and Regulations and amendments under consideration by the MSEC must first be communicated to the Medical Staff for review and comment prior to the proposed Rules and Regulations or amendment being adopted and forwarded to the Governing Board for approval. Any Rules and Regulations adopted by the MSEC and approved by the Governing Board shall be communicated to the Medical Staff in a timely manner.

Rules and Regulations may also be proposed directly to the Governing Board by a petition signed by twenty-five percent (25%) of the Members of the Active Staff. All proposed Rules and Regulations must be presented to MSEC for review and comment before such Rules and Regulations are voted by the Active Staff. All proposed Rules and Regulations become effective only after approval by the Governing Board.

In the event there is a documented need for an urgent amendment to the Rules and Regulations to comply with a law or regulation, the MSEC may provisionally adopt and the Governing Board may provisionally approve an urgent amendment without prior notice to the Medical Staff. In such case, the Medical Staff shall be promptly notified by the MSEC. Members of the Medical Staff may submit any comments regarding the provisional amendment to the MSEC within ten (10) days of receiving notice. The amendment will stand if there is no conflict or dispute. If twenty-five percent (25%) of the Active Staff dispute the amendment, a Joint Conference Committee shall be formed as set forth below.

### **12.4. Medical Staff Policies**

The MSEC, subject to Governing Board approval, may also adopt and amend various policies and procedures to fulfill its obligations and functions as described herein, provided such policies do not conflict with these Medical Bylaws, the ASC Bylaws, System policies, applicable accreditation standards, or applicable Federal and State law. Any Medical Staff policy or procedure that conflicts or is otherwise inconsistent with these documents, standards, or laws shall be considered void and without effect. All policies and policy amendments adopted by the MSEC and approved by the Governing Board shall be communicated to the Medical Staff in a timely manner.

Policies may also be proposed directly to the Governing Board by a majority of the Members eligible to vote at Medical Staff meetings. Before submitting to the Governing Board, proposed policies must be brought before the eligible Members by a petition signed by twenty-five percent (25%) of such Members. Any proposed policies must be presented to the MSEC for review and comment before such policy is voted by the eligible Members. All proposed policies and related amendments become effective only after approval by the Governing Board.

## ARTICLE XIII

### CONFLICT RESOLUTION

#### 13.1. Conflict Resolution

If a conflict or dispute arises or is reasonably expected to arise between the Medical Staff and MSEC regarding the adoption, amendment, or deletion of Bylaws, recommendations to adopt or change Rules and Regulations, policies, or any other issues in dispute between or among the Medical Staff, Governing Board and/or ASC administration, the Medical Staff, the MSEC, ASC Administration, and the Governing Board should work collegially to manage the conflict or dispute. All conflict resolution should initially occur through informal steps. An informal approach may include the use of external resources or a ASC representative trained in conflict management to help facilitate the process. If a resolution cannot be reached through informal means, the matter may be referred to a Joint Conference Committee comprised of either the Medical Staff and Governing Board or Medical Staff and MSEC, as appropriate.

If the conflict is between Members of the Medical Staff and the MSEC, the disputed matter shall be submitted to a Joint Conference Committee upon a petition signed by twenty-five percent (25%) of the Members eligible to vote at Medical Staff meetings.

#### 13.2. Joint Conference Committee

- (a) **Composition:** If the conflict or dispute is between or among the Medical Staff, Governing Board, and/or ASC Administration, the Joint Conference Committee shall consist of three (3) Members of the Governing Board and three (3) eligible Members of the Medical Staff as selected by the Medical Staff President (which may or may not include the Medical Staff President in his/her discretion). In such event, the Chairperson of the Joint Conference Committee shall be the Chairperson of the Governing Board.

If the conflict or dispute is between the Medical Staff and the MSEC, the Joint Conference Committee shall consist of the three (3) Members of the MSEC as selected by the Medical Staff President and three (3) eligible Members of the Medical Staff as designated by the eligible Member submitting the petition. In such event, the Chairperson of the Committee shall be the Medical Staff President.

The COO and Medical Director shall serve as ex-officio Members of any Joint Conference Committee without vote.

- (b) **Duties:** The Joint Conference Committee shall gather information regarding the conflict, meet to discuss various issues in dispute, and work in good faith to resolve the matter in a manner that protects safety and quality throughout the System, ASC, and Medical Staff.

## **ARTICLE XIV**

### **POWERS AND RESPONSIBILITIES OF THE GOVERNING BOARD**

As established and required by applicable state and federal law, the Governing Board serves as the final and ultimate authority in the ASC. As such, the Governing Board is responsible for the management, operation, and control of the ASC. In all matters, unless inconsistent with or contradictory to applicable state or federal law, the ASC Bylaws, as well as the authority of the Governing Board will take precedence over these Medical Staff Bylaws. The procedures and processes set forth in these Bylaws shall not preclude the Board from taking any direct or independent action otherwise authorized under the ASC Bylaws, policies, and procedures, or applicable state and federal law, including but not limited to final determinations made regarding Membership, Clinical Privileges, exclusive arrangements, and Medical Staff closure(s).

Additionally, in the event there is a documented need for an urgent amendment to the Medical Staff Bylaws to comply with a law, regulation, or accreditation standard, the Governing Board may provisionally approve an urgent amendment without prior notice to the Medical Staff. In such case, the Medical Staff shall be promptly notified by written or electronic communication by the Governing Board. Members of the Medical Staff eligible to vote at Medical Staff meetings may submit any comments regarding the provisional amendment to the Medical Staff President within ten (10) days of receiving notice. The amendment will stand if there is no conflict or dispute. If twenty-five percent (25%) of the eligible Members dispute the amendment, a Joint Conference Committee shall be formed pursuant to Section 13.2, above.

## **ARTICLE XV**

### **AMENDMENTS TO MEDICAL STAFF BYLAWS/PRIORITY**

All proposed amendments and restatements (collectively "amendments") to the Medical Staff Bylaws, should first be reviewed and recommended by the MSEC. Requests for amendment may also be recommended by the Members eligible to vote at Medical Staff meetings following timely receipt by the Medical Staff President of a written petition signed by at least twenty percent (20%) of such eligible Members who are in good standing. Proposed amendments may be approved by action at regular or special meetings of the Medical Staff, or alternatively through the balloting procedure, set forth in Article IX, above. Amendments are effective when approved by the Governing Board. Except as otherwise provided above, neither the Medical Staff nor the Governing Board may unilaterally amend these Bylaws.

In the event of a direct conflict between the Medical Staff Bylaws and any other Medical Staff Rule, Regulation or Policy, the language set forth in the Medical Staff Bylaws shall take priority and apply.

## **ARTICLE XVI**

### **DECLARED STATE OF EMERGENCY**

In the event of a Declared State of Emergency, to the extent permitted by applicable Law, the Medical Staff and Governing Board may make temporary exceptions and/or waivers to the requirements and

processes contained in the Medical Staff Bylaws, Rules and Regulations, or related policy, to the extent determined to be reasonably necessary given circumstances attendant to the emergency. Any such exceptions or waivers should be reasonably documented, are temporary in nature, and should be discontinued within a reasonable timeframe upon conclusion of the Declared State of Emergency, unless earlier termination is required by Law. Waivers and exceptions initiated pursuant to this Article are in addition to other emergency and disaster related plans, procedures, and exceptions that may be available to the ASC or Medical Staff, either pursuant to these Bylaws or otherwise, and shall not constitute a violation of the Bylaws, Policies, and Procedures.

**ARTICLE XVII**

**PARLIAMENTARY PROCEDURE**

Any procedural matter not clarified in the Medical Staff Bylaws shall be evaluated and acted upon by the Medical Staff Officers and Chairperson as appropriate, in conjunction with either the Standard Code of Parliamentary Procedure or Robert's Rules of Order, whichever has been adopted by the Medical Staff.

**ARTICLE XVIII**

**ADOPTION**

The Medical Staff Bylaws, excluding the Medical Staff Rules and Regulations, shall be adopted at any regular or special meeting of the Active Staff, and shall replace any previous Medical Staff Bylaws, and shall become effective immediately upon approval by the Governing Board.

**ARTICLE XIX**

**RECORD OF DOCUMENT REVISIONS**

Date	Article/Section Modified
December 17, 2025	Amended and Restated in Entirety

**ADOPTED BY THE MEDICAL STAFF:**

By:  \_\_\_\_\_  
Micah Smith (Jan 6, 2026 15:10:45 EST)  
 Micah Smith, M.D., Medical Staff President  
 Date: 01/06/2026

**APPROVED BY THE BOARD OF MANAGERS:**

By:  \_\_\_\_\_  
Marceline Rogers (Jan 13, 2026 15:39:49 EST)  
 Marceline Rogers, Chairperson  
 Date: 13/01/2026

**APPENDIX A**

**NON-PHYSICIAN PRACTITIONERS**

- (a) Advanced Practice Registered Nurses
- (b) Physician Assistants
- (c) Certified Registered Nurse Anesthetists

## **APPENDIX B**

### **MEDICAL STAFF ORGANIZATIONAL PLAN**

The Medical Staff Executive Committee has approved the following committees, which serve as Medical Staff Standing Committees. All such committees are hereby constituted as Peer Review Committees to the extent they are engaged in lawful Peer Review activities.

#### **A. Infection Control Committee**

1. Composition:

The Infection Control Committee shall consist of:

- (a) The person(s) directly responsible for the ongoing infection control activities and the development and implementation of policies governing control of infections and communicable diseases (the "Infection Preventionist") of the ASC;
- (b) The Vice President of Operations of the ASC; and
- (c) The two (2) Members of the Medical Staff, one of whom must be the Medical Director of the ASC.

The Committee members may invite other individuals, including, but not limited to, Quality Accreditation Specialist ("QAS"), to join as an *ad hoc* member.

2. Duties:

The duties of the Infection Control Committee shall include the development and maintenance of an ongoing program designed to prevent, control, and investigate infections and communicable diseases at the ASC. The program shall include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. The program shall be under the direction of the Infection Control Committee, which shall include members who have training in infection control. The program shall be an integral part of the ASC's quality assessment and performance improvement program. In addition, the duties of the Infection Control Committee shall include:

- (a) To provide surveillance of the ASC's infection potential, to review and analyze actual infections, and to recommend corrective and preventative measures to minimize infection hazards;
- (b) To develop standards for sanitation and medical asepsis at the ASC, including standards for the provision of a functional and sanitary environment for the provision of surgical services at the ASC by adhering to professionally acceptable standards of practice;
- (c) To authorize the Chief Operating Officer of the ASC to take corrective and preventative action and measures as necessary and appropriate to prevent infection problems;

- (d) To review surgical cases for indications for surgery and variations in pre and post- operative diagnoses;
- (e) To review reports on all tissues removed and submitted to the Pathologist for examination;
- (f) To recommend further studies or reviews to be performed and corrective actions to be taken;
- (g) To comply with all responsibilities as set forth in the ASC/Medical Staff Rules and Regulations regarding the Infection Control Committee; and
- (h) To generally provide a plan of action for preventing, identifying, and managing infections and communicable diseases and for implementing corrective and preventative measures that result in improvement.

3. Meetings:

The committee shall generally meet quarterly, but in all instances will meet as frequently as needed to fulfill its duties.

Only Members of Medical Staff are eligible to vote.

**B. Quality Resource Management (“QRM”) Committee**

1. Composition

The QRM Committee shall consist of:

- (a) The President of Medical Staff;
- (b) At Least Two (2) Members of Medical Staff specializing in Orthopedics;
- (c) At Least One (1) Member of Medical Staff specializing in Anesthesiology;
- (d) The Vice President of Operations of the ASC;
- (e) The Quality Accreditation Specialist (“QAS”).

The Committee members may invite other individuals, including, but not limited to, Department Leader(s), to join as an *ad hoc* member.

2. Duties:

The ASC Medical Staff shall have a quality assessment and improvement program which shall incorporate and address ASC-wide quality assessment and improvement matters. The QRM Committee shall document any action taken regarding ASC quality assessment and improvement matters; the QRM shall also document the outcome of

such action taken, to include effectiveness, follow-up, and/or impact on patient care. Any and all QRM matters related to the ASC shall be reviewed and approved by the Governing Body of the ASC. The duties of the QRM regarding the ASC shall include all matters set forth in the ASC Medical Staff Rules and Regulations, including, without implied limitation, the evaluation of:

- (a) All services, including services furnished by a contractor.
- (b) All functions, including, but not limited to, the following:
  - (i) Discharge and transfer;
  - (ii) Infection control;
  - (iii) Medication errors; and
  - (iv) Response to patient emergencies.

3. Meetings, Reports, and Recommendations:

The QRM Committee shall generally meet at least quarterly, but as often as necessary to perform its duties and shall maintain a permanent record of its findings, proceedings, and actions. The QRM shall submit reports of its activities to the Medical Staff and the Board on a regular basis.

Only Members of Medical Staff are eligible to vote.