ASC Peer Review: The Clock Starts Running January 1, 2016

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Effective, January 1, 2016, all Ambulatory Surgery Centers will be required to conduct peer review on their physicians every two years. Senate Bill 396 will have the greatest impact on smaller ASCs, including physician-owned facilities with just a single physician on staff. Larger ASCs, those with more than 25 physicians, are already required to conduct peer review under the general language of the peer review statute, California Business & Professions Code § 805 et seq. Other ASCs may also conduct peer review to satisfy accreditation or corporate requirements. For those who are not, it will be a new day, marking the further emergence of ASCs as a force in health care delivery.

A New Twist on Peer Review

Although the two-year timeframe suggests that the peer review required by the new law is only the biennial privilege renewal process used in hospitals, it is not. Nor is it the same prosecutorial style peer review conducted by hospital Medical Staffs, which is typically initiated in response to a specific patient care incident or complaint. Even though the definition of peer review in the new law is identical to the definition of peer review in the peer review statute, the new law requires something different. Under the new law, ***every*** ASC staff member must be peer reviewed at least every two years, without regard to whether or not there has been a patient care complaint or sentinel event. This is variation on current peer review practices and is a close equivalent to the Ongoing Professional Practice Evaluation (OPPE') that is a routine peer review tool utilized by hospital medical staffs and required by the Joint Commission. As the name suggests, this is not a process to be left to the end of 2018. The two-year deadline in the new law is the end of a process that ought to start immediately.

Action Items

ASCs implementing peer review for the first time and other ASCs revising and upgrading their peer review procedures will face several challenges.

Bylaws: The Bylaws are the critically important document that sets peer review standards and procedures and contains fair procedure guarantees for physicians. There are many stakeholders in the adoption or modification of Bylaws and the process must be scheduled to allow time for participation by all of them.

Data collection: The medical outcomes criterion requires that the ASC have the data management capability to track, isolate and review patient information in a form appropriate to the peer review function. Coordinating IT and peer review functions to assure that the proper metrics are being used and that the data will be available in usable form at the end of two years should be done now.

Structure: Peer review in a smaller ASC presents some distinctive challenges not found in a hospital. In a hospital, the Medical Staff, which conducts peer review, and the governing board, which makes final peer review decisions, are separate and independent entities. In a smaller ASC, the two will typically overlap. A hospital with a large medical staff of diverse specialists can typically find impartial physicians to perform the peer review function. In an ASC, almost everyone participating in peer review is likely to be a business partner with or competitor of the physician under review, making it difficult to find reviewers free from an appearance of bias. At least one risk to be mindful of in structuring the peer review process is an enhanced susceptibility to lawsuits alleging sham and retaliatory peer review.

SB 396 should not be taken as a mandate to slavishly mimic the existing peer review structure used in hospitals. At least some thought should be given to alternative and innovative approaches. Based on the particular circumstances of the ASC, these may include outsourcing to an independent professional review organization and, depending on the ASC's membership, joint efforts with local hospitals or larger medical groups.

Closely related to the change in peer review requirements is a change in credentialing practice. Under current law, ASCs do not have access to the disciplinary history the California Medical Board maintains on a physician, including non-public matters such as 805 reports of adverse Medical Staff action submitted to the Medical Board. The new law not only gives ASCs access to this information, but requires them to query the Medical Board as part of the credentialing process. The quality of credentialing decisions is a critically important part of the quality assurance function and goes hand in hand with quality peer review. This is a welcome and common sense change.

Another new provision relates to inspections and allows for a curious announced unannounced inspection of ASCs under Medical Board supervision. The accreditation entities designated by the Medical Board will now be permitted to conduct follow up inspections after the initial accreditation. Although these follow up inspections are described as unannounced, the accreditation entity must give an ASC 60-days advance notice of the inspection. The impact of this new provision will depend on how often and effectively the accreditation entities use this new discretionary authority.

Overall, SB 396 is being greeted as a welcome first step in improving ASC oversight. However, more change and enforcement for non-compliance is likely to follow. ACSs are playing an increasingly prominent role in the health care delivery system. The extent of the regulation to which they are subject is certain to increase commensurate with their increasing prominence.

Nossaman attorneys have been representing medical staffs and physicians for more than 40 years. Our healthcare expertise extends to all aspects of medical staff operations, including counseling hospitals and medical staffs on investigating and taking action in peer review matters, developing and revising medical

staff bylaws, rules and policies, and dealing with emergency department coverage, exclusive contracts, allegations of anti-competitive activities of fellow physicians and with well-being issues including disruptive or impaired physicians.