DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
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BUMEDINST 6010.31A
BUMED-N10G/N01L
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BUMED INSTRUCTION 6010.31A

From: Chief, Bureau of Medicine and Surgery

Subj: CLINICAL ADVERSE ACTIONS AND HEALTH CARE RELATED MISCONDUCT

Ref: (a) 10 U.S.C.
(b) DoD Instruction 6025.13 of 26 July 2023
(c) OPNAVINST 6320.7B
(d) DHA-PM 6025.13
(e) SECNAVINST 1754.8
(f) BUMEDINST 6010.30
(g) SECNAV M-1850.1 of September 2019 (Chapter 4)
(h) OPNAVINST 7220.17
(i) SECNAVINST 1920.6D
(j) 5 U.S.C.

Encl: (1) Definitions
(2) Privileging Authority Initial Action
(3) Quality Assurance Investigative Procedures
(4) Clinical Adverse Action Process
(5) Peer Review Hearing Script
(6) Appeal Process
(7) Health Care Related Reportable Misconduct
(8) Sample Letters
(9) Document Checklist

1. Purpose. To establish policy, assign responsibility, and prescribe procedures for the management and reporting of clinical adverse actions and health care related misconduct for privileged and non-privileged health care providers of the Department of the Navy (DON), per the authorities in reference (a), section 1073 and the requirements in reference (b). Clinical Adverse Actions (CAAs) are part of the Navy's Health Care Risk Management Program with emphasis on promoting safe patient care and health care environments in operational settings consistent with the guidance in reference (c). CAAs negatively impact the clinical practice of licensed health care providers and are taken in response to findings of incompetence, misconduct or any other professional conduct which adversely affects or could adversely affect the health or welfare of a patient or the delivery of health care. Additionally, criminal convictions and government administrative actions based on acts or omissions by health care providers or suppliers that affect or could affect the payment, provision, or delivery of a health care item or service are subject to review and reporting to the National Practitioner Data Bank (NDPB).

2. Cancellation. BUMEDINST 6010.31.

3. Scope and Applicability. This instruction applies to all Navy and Marine Corps medical and dental health care personnel (e.g., Active Component (AC), Reserve Component (RC), civilians, contractors, and volunteers) who are assigned to, employed by, contracted to, or employed within DON units and activities. This instruction is not applicable to CAAs involving providers who are credentialed and or privileged through a Defense Health Agency military medical treatment facility; those actions are governed by reference (d), volume 3 and the report authority is the Director, Defense Health Agency. This instruction is also not applicable to CAAs involving individuals who are credentialed and or privileged through Commander, Navy Installations Command; those actions are governed by reference (e).

4. Background. Per reference (a), section 8077, Surgeon General of the Navy serves as the Chief, Bureau of Medicine and Surgery (BUMED) and principal advisor to the Secretary of the Navy (SECNAV) on all health and medical matters of the Navy and Marine Corps. Reference (a), section 1073c authorizes the Surgeon General of the Navy to manage clinical privileging, scope of practice, and quality of health care in the delivery of operational clinical services under the control of combatant commands on ships and installations outside of military medical treatment facilities (MTF). Military Health System (MHS) Clinical Quality Management (CQM) programs include health care risk management. CAAs and health care related misconduct are professional review activities under DON's health care risk management program. Per reference (b), the Surgeon General of the Navy is accountable for the success of clinical quality management within DON with respect to all health care provided under the authority of SECNAV.

5. Definitions. See enclosure (1).

6. Policy

a. Basic Principles and Guidance

(1) Navy Medicine provides safe and effective health care by requiring its health care providers to be properly qualified, trained, and competent to perform their clinical duties per reference (f). Professional review activities are indicated when there are allegations or concerns for incompetence, misconduct or any other professional conduct which adversely affects or could adversely affect the health or welfare of a patient or the delivery of health care.

(2) A robust Professional Practice Evaluation system is an important risk mitigation strategy for preventing harm and increasing the reliability of safe, high quality clinical outcomes. Required routine and regular evaluation of privileges or practice provides an opportunity for continuous professional learning and improvement in addition to validating clinical proficiency. Non-adverse procedures for routine and regular evaluations include Ongoing Professional Practice Evaluations (OPPE), Focused Professional Practice Evaluations (FPPE), monitoring, mentoring, training, and education. Specialty leaders may be consulted to provide expertise for

scope of practice and professional standards for their given specialty when developing plans for non-adverse interventions. A period of FPPE may also be directed to address concerns of substandard care, or incompetence, when there is not sufficient information to warrant immediate removal from clinical practice through summary suspension and initiation of a quality assurance investigation. While placement on a FPPE is non-adverse, the failure to successfully complete a FPPE may result in the initiation of a clinical adverse action.

(3) Professional review activities are conducted per section 11112 of Title 42, U.S. Code, reference (b), and this instruction, and have the potential for a health care provider to be reported to the NPDB, state(s) of licensure, and other applicable certifying or regulatory agencies. BUMED is the sole Report Authority to report providers under their privileging authority to such entities. Reports by Chief, BUMED to the NPDB include summary suspensions of clinical privileges lasting longer than 30 calendar days, final CAAs when directed by Chief, BUMED, and government administrative actions and criminal convictions when conduct by providers are related to the delivery of care.

(4) Before initiating a CAA, a Privileging Authority, as designated in reference (f) or been granted delegated privileging authority in writing, will consult with BUMED Associate Counsel (BUMED-N01L) for appropriate guidance and review of all notification documentation prior to issuance to ensure due process proceedings as described in this instruction and in enclosures (2) through (6) are followed. Notification of summary suspension to providers under review will be made in writing, delivered in person when possible, or otherwise delivered by secure electronic system with confirmation of receipt or return certified requested mail to the last known address of record.

(5) Professional conduct which adversely affects or could adversely affect the health or welfare of a patient, or the delivery of health care include but are not limited to unprofessional or unethical acts, violations of law (local, State and Federal), offenses under the Uniform Code of Military Justice, or violations of other military regulations. Such conduct may be the basis for both a CAA and disciplinary or administrative action, the conclusion of which may result in separate reports to the NPDB. When disciplinary action is contemplated, consultation between the Privileging Authority and the staff judge advocate (SJA) or other advising Navy counsel for the commanding officer taking the action, is required to ensure proper military and or civilian personnel procedures are followed.

(6) Completed criminal, disciplinary, and administrative actions against health care providers that affect or could affect the payment, provision, or delivery of a health care item or service must be forwarded to the respective Privileging Authority for review and forwarding to Chief, BUMED for reporting to the NPDB, as appropriate. Enclosure (7) provides requirements for reporting health care related misconduct.

(7) Impaired health provider programs (IHPP) are designed to provide support, assistance and coordination or advocacy for wellness of impaired health care providers per reference (b). An impaired health care provider is one who is under evaluation for or is diagnosed with any of

the following that adversely affects or could adversely affect their ability to provide appropriate health care: a medical condition; a mental health condition; or other impairment associated with substance misuse.

(a) Referral to provider wellness is not punitive nor is it a CAA. Privileging Authorities without the resources to have their own IHPP will require affiliation with an established IHPP within the Navy or DHA.

(b) The IHPP recommends plans for management of impaired health care providers to the Privileging Authority, to include recommendations on appropriate limitations on continued privileges or practice, which may result in a temporary reassignment to non-direct patient care activities. Such reassignment is considered an administrative personnel action, non-adverse, and not reportable to the NPDB. Consult with BUMED Associate Counsel for sample reassignment letter.

(c) Notwithstanding the emphasis on wellness, CAA due process should be initiated in cases in which a provider is or may be impaired and does not self-refer or enroll in the IHPP as directed, lacks insight, is unwilling to address their condition, is not compliant with treatment or provider wellness program requests, or fails to complete or relapses after a treatment program.

(d) If a CAA is taken against a health care provider for misconduct or incompetence related to impaired health, such action must be reported by Chief, BUMED to the NPDB, state(s) of licensure, or other applicable certifying or regulatory agencies as appropriate.

(e) Providers who end affiliation with the MHS while in continued monitoring by the IHPP or those who are impaired due to substance misuse that do not successfully complete the rehabilitation program in which they are enrolled, will be considered by the appropriate Privileging Authority for reporting recommendation to Chief, BUMED. Chief, BUMED will report to the respective state(s) of licensure and other applicable certifying or regulatory agencies as appropriate.

(8) Medical Corps officers referred into the disability evaluation system will have a separate command evaluation to include the officer's current overall level of function and a peer review delineating clinical privileges per subparagraph 5b(9)(c) of reference (g).

(9) A provider may not voluntarily surrender or self-relinquish clinical privileges or practice to prevent or avoid an investigation into allegations of incompetence, misconduct, or any other professional conduct. Severing the employment relationship (e.g., transfer, separation, retirement, or resignation) or negotiating a contractual or employment settlement (e.g., voluntary relinquishment of some or all privileges or practice) to avoid initiation or completion of an CAA is not permitted.

(10) A provider who voluntarily or involuntarily ends affiliation with the DON while in summary suspension has the right to request continued due process through the convening of a

peer review hearing panel and appeal. The request must be submitted in writing by the provider to the Privileging Authority within 5 calendar days following their knowledge of the change in affiliation status. If the provider fails to submit the request for this right, it is considered waived. If the right to further due process is waived the following action will be taken: a quality assurance investigation will be completed; the provider will be given a redacted copy of the investigative report, without enclosures, and afforded an opportunity to submit a statement; the investigation and statement, if submitted, will be forwarded to an ad hoc medical executive or credentials review committee for evaluation and recommendation to the Privileging Authority; the Privileging Authority will give written notice to the provider of the decision on their privileges or practice and such decision will be final. The case file will be forwarded to Chief, BUMED for review and reporting to the NPDB and other entities as appropriate.

(11) Allegations of incompetence, misconduct, or any other professional conduct that adversely affects or could adversely affect the health or welfare of a patient or the delivery of health care against a provider who no longer is assigned to the Privileging Authority where the events/actions occurred, but is still affiliated within the Military Health System, remains subjected to professional review. The losing Privileging Authority initiates the clinical adverse action due process, to include the quality assurance investigation, and notifies the provider in writing. A copy of the notification is sent to the gaining Privileging Authority. The losing Privileging Authority completes the due process proceedings and notifies the gaining Privileging Authority of the final decision.

(12) A CAA may be initiated against a health care provider no longer affiliated with the Military Health System for allegations of incompetence, misconduct or any other professional conduct that adversely affects or could adversely affect the health or welfare of a patient or the delivery of health care within 24 months after the provider's privileges or practice ceased under the respective Privileging Authority. In exceptional circumstances, as determined by the Privileging Authority, a CAA may be initiated beyond the typical 24-month period. The Privileging Authority under whose authority the provider held privileges or practice at the time of the alleged events convenes a quality assurance investigation into the allegations. The provider will be notified in writing of the basis for the investigation, given an opportunity to review a redacted copy of the investigation (without enclosures) once completed, and allowed to submit a written statement. If the Privileging Authority proposes a CAA decision based on the results of the quality assurance investigation and recommendation by the credentials committee, the provider will be notified in writing of the decision and informed of the right to elect or waive a peer review hearing panel. If the Privileging Authority determines that a CAA would not be appropriate based on the evidence, they will notify the provider in writing.

(13) If a provider's privileges are due to expire while in summary suspension, no renewal action is taken on the privileges affected as stated in the summary suspension notice. The affected privileges remain in summary suspension during the entire due process proceedings, even if the privileges have expired. In cases where the provider has not had all of their privileges placed in summary suspension, the unaffected privileges may be renewed, as appropriate.

(14) Final CAAs involving restriction of privileges or practice require supervision by a proctor and may result in limited opportunities for knowledge and or skills remediation. However, comprehensive retraining is not permitted (e.g., repeating a year of residency or conducting a period of restriction in a residency program). In cases where the final decision is a restriction of privileges or practice for providers no longer affiliated with the Military Health System, such providers may complete the required supervised practice or remediation through a civilian facility or education program. The former provider may then submit written documentation of the completed remedial actions to the Privileging Authority that took the action with a request for the affected privileges to be reinstated. If the request is granted, a revision to action report will be made to the NPDB by Chief, BUMED.

(15) Military providers must meet and maintain requirements for receipt of special pays. For providers who are not privileged and practicing, their eligibility for special pays must be re-evaluated per reference (h).

(16) Health care providers whose privileges or practice have been placed in summary suspension, are under investigation, and are pending due process procedures, should not deploy, be reassigned to another clinical billet, or execute permanent change of stations (PCS) orders. Exceptions for PCS may be considered to move providers from OCONUS or remote locations. Final clinical adverse actions may warrant administrative separation for military officers per enclosure (6) of reference (i) and personnel actions for Federal civilian employees per reference (j), sections 500 to 596.

(17) Timelines are in calendar days and are established to allow individuals adequate time to prepare and sufficiently participate in the proceedings, and to facilitate timely resolution of a CAA. If the final day for any specified timeline falls on a weekend or federal holiday, the timeline is extended to the next business day. Privileging Authorities may grant timeline extensions on the provider's behalf for good cause throughout the process and then document the extension and rationale for such. Privileging Authorities will make every effort to meet the timelines outlined in this instruction. While it is important that time limits in this instruction are met, no rights will accrue to the benefit of an affected provider, in an otherwise proper action, based solely on the Privileging Authority's failure to meet such time limits.

(18) To ensure compliance with required due process and the procedures in this instruction, all notifications to the health care provider under review will be in writing, delivered in person, when possible, otherwise by certified return receipt requested mail, or secure electronic system with confirmation of receipt.

b. Clinical Adverse Action Process. The process for adversely affecting the privileges or practice of health care providers requires the following: written notification, completed quality assurance (QA) investigation, provider opportunity for review of redacted QA investigation report and statement submission, medical or nurse executive ad hoc committee review and recommendation, Privileging Authority proposed decision, election or waiver of a peer review hearing panel, peer review hearing panel report and provider statement on panel report (if

elected), Privileging Authority final decision, provider appeal to Chief, BUMED, (if not waived), and final review and approval of action by Chief, BUMED. Further details on this process can be found in enclosures (2) through (6). Sample letters are provided in enclosure (8).

7. Responsibilities

a. Privileging Authorities must:

(1) Comply with the requirements of this instruction.

(2) Be designated a privileging authority per reference (f) or been granted delegated privileging authority in writing, in order to initiate the procedures in this instruction. A delegated privileging authority cannot further delegate this responsibility. When a CAA is initiated, the privileging authority must be actively involved in the entire process. It is strongly recommended that an acting privileging authority only initiate these procedures in those instances where the privileging authority is absent, and circumstances require immediate action. Every effort should be made to notify and consult with an absent privileging authority prior to initiating action.

(3) Consult with BUMED Associate Counsel (N01L) before initiating a CAA and continuing throughout the process. Ensure all notification issuances to the provider are reviewed by counsel prior to signature.

(4) Investigate allegations of provider incompetence, misconduct or any other professional conduct which adversely affects or could adversely affect the health or welfare of a patient or delivery of health care. Prompt action is necessary to safeguard patient care and protect individual rights.

(5) Promptly notify other Privileging Authorities (DoD and civilian) under who the provider holds privileges or practices (i.e., temporary assignments on an ICTB, off-duty employers or civilian facilities if participating in an outside training or skills sustainment agreement) when placing a provider in summary suspension.

(6) Ensure the withdrawal of permission for the privileged and non-privileged provider to engage in clinically related employment outside DON when notification of summary suspension is issued and continued until all due process procedures are completed. Notification of summary suspensions must be given to any military or civilian health facility where the provider is currently practicing.

(7) Ensure appropriate consultation with either the civilian human resources office (HRO) or contracting officer when a CAA is initiated against a Federal civil service employee or contract employee. Such consultation ensures that appropriate employee guidelines or contract provisions are also followed. Copies of summary suspension letters will be provided to the respective HRO or contracting office.

(8) Issue decisions on all CAAs and ensure that due process, notification procedures, and clinical adverse action decisions comply with this instruction. All decisions must be supported by the evidence in the peer review record.

(9) Timely forward all final actions that result in an adverse privileging or practice decision by preparing a memorandum to Chief, BUMED and include the full and complete peer review record. A document checklist is provided in enclosure (9) to verify the record is complete. The full record is to be sent via secured electronic delivery (e.g., DoD SAFE) to BUMED Associate Counsel (N01L). If an appeal of the decision is submitted in the case, address main issues raised in the appeal in the forwarding memorandum.

(10) Coordinate with the command legal office to ensure the results of completed disciplinary or administrative actions involving health care related misconduct of privileged and non-privileged providers are forwarded to BUMED Associate Counsel (N01L) with recommendation for reporting to the NPDB as appropriate.

b. Medical Staff Professionals must:

(1) Manage the command's CAA process, track open cases for the Privileging Authority, and provide timely updates on open cases to assigned BUMED Associate Counsel (N01L). Serve as the primary point of contact and maintain coordination with the Chair of the Medical Executive or Credentials Review Committee, Chief Medical Officer, or Chief Nursing Officer. Confirm that any correspondence related to this process is reviewed by BUMED Associate Counsel prior to Privileging Authority signature.

(2) In consultation with BUMED Associate Counsel, confirm delivery and receipt of the Summary Suspension notification letter to all DoD and civilian clinical sites where the provider is engaged in clinical activities.

(3) Assist appointed quality assurance investigating officers (IO) in the collection of records or documents required for review and inclusion in the quality assurance investigative report.

(4) Provide copies of documents under review to appointed members of the ad hoc medical executive or credentials review committee, peer review hearing panel members and subject provider.

(5) Provide the listed assistance in subparagraphs 7b(5)(a) through 7b(5)(d) when a peer review hearing panel is convened:

(a) Support the appointed privileging authority representative in the preparation of materials for peer review hearing panels.

(b) Confirm delivery and receipt of the peer review hearing panel exhibits to the appointed legal advisor to the panel.

(c) Confirm delivery and receipt of the peer review hearing panel transcripts to the Chair of the peer review hearing panel and assist with the review of the hearing transcripts.

(d) Confirm delivery and receipt of the peer review hearing panel report, exhibits, and transcripts to the provider under review within 30 calendar days of hearing completion.

(6) Confirm delivery and receipt of all notification letters to the subject provider.

(7) Affirmatively provide BUMED Associate Counsel within 5 calendar days of issuance, copies of documentation regarding summary suspensions, ad hoc executive or credentials review committee recommendations, privileging authority proposed decisions, health care provider statements or elections, notices of peer review hearing panel, peer review hearing panel reports, privileging authority final decisions, and appeals of final decisions in all CAA cases.

(8) Confirm final actions that result in an adverse privileging or practice decision, or provider appeal if submitted, are forwarded to Chief, BUMED within 14 calendar days of the privileging authority's final decision letter. The case file will be sent by memorandum from the Privileging Authority to Chief, BUMED and will include the full and complete peer review record. A document checklist is provided in enclosure (9) to verify the record is complete. The full and complete peer review record is to be sent via secured electronic delivery (i.e., DoD SAFE) to BUMED-N01L.

c. Director, High Reliability Office, Clinical Quality Management (BUMED-N10G) must:

(1) Manage the CAA program and implement policy in coordination with BUMED Office of General Counsel.

(2) Assist Privileging Authorities in identifying appropriate clinical peers to conduct quality assurance investigations, participate as members on the ad hoc medical executive or credentials review committee, or as members on the peer review hearing panel.

(3) In consultation with BUMED Office of General Counsel, maintain CAA records.

(4) In consultation with BUMED Office of General Counsel, arrange for a clinical peer review and convening of a healthcare professional appropriate panel for appeals of CAA decisions.

(5) In coordination with BUMED Office of General Counsel, ensure summary suspensions of clinical privileges lasting longer than 30 calendar days are reported to the National Practitioner Data Bank (NPDB) and to state(s) of licensure. A revision-to-action report is also required to the NPDB at the conclusion of the action.

(6) When directed by Chief, BUMED, and in coordination with BUMED General Counsel, ensure final CAAs are reported to the appropriate reporting entity (NPDB, state(s) of licensure, regulatory agencies, and professional organizations) within 30 calendar days of Chief, BUMED's decision. Ensure CAA information is entered into the Department of Defense (DoD) electronic database (i.e., Centralized Credentials and Quality Assurance System (CCQAS)).

(7) When directed by Chief, BUMED, and in coordination with BUMED Office of General Counsel, ensure criminal convictions and government administrative actions are reported to the NPDB, state(s) of licensure, regulatory agencies, and appropriate professional organizations within 30 calendar days of Chief, BUMED's decision. Ensure these actions are entered into the DoD electronic database (i.e., Centralized Credentials and Quality Assurance System (CCQAS)).

(8) In consultation with BUMED Office of General Counsel, respond to queries from state licensing boards, employers or regulatory agencies on current or former DON health care providers who have been the subject of a final CAA or reportable health care related misconduct.

(9) Coordinate with BUMED Office of General Counsel on the appropriate office to respond to requests for release of DON medical quality assurance records (MQAR) and or information protected under reference (a), section 1102. BUMED Director, High Reliability Office, Clinical Quality Management (BUMED-N10G) and BUMED General Counsel have authority to release DON MQARs.

d. <u>BUMED Office of General Counsel (BUMED-N01L) must</u>:

(1) Provide legal support to BUMED-N10G in meeting the requirements of this instruction.

(2) Provide template sample letters and updates to templates as described in this instruction.

(3) Assign separate associate counsel to advise Chief, BUMED and Privileging Authorities on the requirements of this instruction to avoid potential conflicts of interest. Ensure assigned associate counsel perform the following responsibilities:

(a) Provide the appropriate legal support and consultations throughout the CAA process. This includes but is not limited to: providing guidance to quality assurance investigating officers and reviewing quality assurance investigative reports for legal sufficiency;

proactively track pending cases and ensure timelines in this instruction are met; complete legal sufficiency reviews in writing when required; and review all notices and other documentation related to this process prior to signature by the IO, medical executive or credentials review committee, and Privileging Authority, as appropriate.

(b) The assigned associate counsel to Chief, BUMED review final CAA cases confirming the peer review record is complete, requirements for due process have been met, and written legal briefs are completed to assist BUMED reviewing authorities in making recommendations for action to Chief, BUMED. This assigned associate counsel is also required to prepare written CAA decision and or other notification letters for Chief, BUMED action.

(c) The assigned associate counsel to Chief, BUMED maintains a tracking process for pending CAA cases that is routinely updated and briefed to Chief, BUMED.

(4) Coordinate with BUMED-N10G to respond to requests for release of DON MQARs and or information protected under section 1102 of reference (a). BUMED Counsel and BUMED-N10G have authority to release DON MQARs.

(5) Identify an attorney advisor who will facilitate due process proceedings for a Peer Review Hearing and advise its panel members. The attorney advisor can be a uniformed attorney or civilian counsel not assigned to BUMED. Assigned associate counsel to Privileging Authorities or to Chief, BUMED must not be assigned to this role.

8. Confidentiality

a. MQARs generated through professional review activities are protected in accordance with reference (a), section 1102. These documents must not be released without proper authority from Chief, BUMED or his designee.

b. Aside from the subject of a MQA program action, the identity of any person receiving healthcare services from the DoD, or the identity of any other person associated with the DoD for purposes of an MQA that is disclosed in an MQA record must be redacted per reference (a) before any disclosure is made outside of the DoD.

9. Records Management

a. Records created as a result of this instruction, regardless of format or media, must be maintained and dispositioned per the records disposition schedules located on the Department of the Navy Directorate for Administration, Logistics, and Operations, Directives and Records Management Division portal page at https://portal.secnav.navy.mil/orgs/DUSNM/DONAA/DRM/Records-and-Information-Management/Approved%20Record%20Schedules/Forms/AllItems.aspx.

b. For questions concerning the management of records related to this instruction or the records disposition schedules, please contact the local records manager or the Department of the Navy Directorate for Administration, Logistics, and Operations, Directives and Records Management Division program office.

10. Review and Effective Date. Per OPNAVINST 5215.17A, BUMED-N01G will review this instruction annually around the anniversary of its issuance date to ensure applicability, currency, and consistency with Federal, Department of Defense, Secretary of the Navy, and Navy policy and statutory authority using OPNAV 5215/40 Review of Instruction. This instruction will be in effect for 10 years, unless revised or cancelled in the interim, and will be reissued by the 10-year anniversary date if it is still required, unless it meets one of the exceptions in OPNAVINST 5215.17A, paragraph 9. Otherwise, if the instruction is no longer required, it will be processed for cancellation as soon as the need for cancellation is known following the guidance in OPNAV Manual 5215.1 of May 2016.

11. Forms and Information Management Control

a. Forms. SF Form 50 Notice of Personnel Action is available at: https://www.opm.gov/forms/standard-forms/.

b. Information Management Control. Reports required in this instruction are exempt from reports control per Secretary of the Navy Manual 5214.1 of December 2005, part IV, subparagraph 7k.

D. K. VIA

Releasability and distribution:
This instruction is cleared for public release and is available electronically only via the Navy Medicine Web site, http://www.med.navy.mil/directives/Pages/BUMEDInstructions.aspx

DEFINITIONS

1. Adverse Practice Action. Restriction, reduction, or revocation of the clinical practice of a non-privileged provider as a result of due process professional review action.

2. Adverse Privileging Action. Denial, restriction, reduction or revocation of clinical privileges as a result of a due process professional review action.

3. Clinical Adverse Action. Action invoked against a healthcare provider, privileged or not, with the result that the authority to practice clinically is adversely affected. Adversely affected privilege(s) or practice are the result of a due process professional review action based on evidence of incompetence, misconduct or any professional conduct which adversely affects, or could adversely affect, the health or welfare of a patient or delivery of health care. This is a collective term used in this instruction that encompasses both an adverse privileging action and an adverse practice action.

4. Clinical Privileges. Permission granted by the privileging authority to provide medical and other patient care services. Clinical privileges define the scope and limits of practice for privileged providers and are based on capability of the health care facility, licensure, relevant training and experience, current competence, health status, judgment, and peer and department head recommendations.

5. Credentials. The documents that constitute evidence of appropriate education, training, licensure or certification, experience, and expertise of a healthcare provider.

6. Denial of Clinical Privileges. Refusal to grant requested privilege(s) to a provider at the time of initial application or renewal. Denials that result from a professional review action following appropriate due process proceedings are reported to the NPDB. Denial of privileges due to facility-related limitations or its established threshold criteria for that particular privilege(s), are not adverse nor reportable to the NPDB; these are considered decisions based on eligibility and are not deemed the results of a professional review action.

7. Focused Professional Practice Evaluation (FPPE). A process whereby the organization evaluates the privilege(s) or practice of a health care provider who does not have documented evidence of competently performing the requested privilege or of demonstrated practice competency at the organization. This process may also be used when concerns arise regarding a health care provider's ability to provide safe, high quality patient care. FPPE is a time-limited period during which the organization evaluates and determines the health care provider's professional performance. Privilege(s) or practice remain intact during the period of FPPE. Placement on a FPPE is not adverse; however, a provider's inability to successfully complete a period of FPPE may be the basis to initiate a clinical adverse action. Criteria and methods for a FPPE can be found in reference (f).

8. Health Care Provider. Any service member, civilian employee of the DON, or contract employee authorized by the DON to perform health care services.

9. Incompetence. Lacking sufficient medical or clinical knowledge, skills, ability, or judgment to a degree likely to endanger the welfare of a patient or the delivery of health care. Incompetence also includes an inability to practice safely due to physical impairment, psychological impairment or mental disorder, and alcohol or other substance misuse.

10. Legal Sufficiency Review. A determination by the assigned BUMED Associate Counsel or other DoD Counsel to a deciding official that a proposed action meets applicable legal requirements.

11. Monitoring and Evaluation. A well-defined, time-limited, well documented plan of FPPE to confirm a health care provider possesses the knowledge, skill, ability and judgment to render safe and effective healthcare. It must include a documented plan with delineation of clear expectations and measures of success. It requires a preceptor (i.e., clinical peer) who provides full written evaluation of the monitoring period, with regular interval feedback to both the provider and the medical executive or credentials committee. Privilege(s) or practice remain intact during the period of monitoring and evaluation.

12. Medical Quality Assurance Records (MQAR). The proceedings, minutes, and reports that emanate from quality assurance program activities and are produced or compiled by the DON as part of medical quality assurance as defined in reference (a), section 1102.

13. National Practitioner Data Bank (NPDB). A web based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners, providers and suppliers. The NPDB is managed by the Department of Health and Human Services in accordance with Title 42 United States Code, section 11101.

14. Peer. A health care provider with generally similar privileges, practice, clinical specialty and level of training (i.e. residency training and or subspecialty fellowship training).

15. Peer Review. Any assessment of the quality of medical care carried out by a health care provider, including any such assessment of professional performance, any patient safety program comprehensive systematic analysis or report, or any other such assessment carried out by a health care provider under the provision of this instruction.

16. Privileging Authority. Designated official who grants permission to health care providers to deliver specific care, treatment, or services within well-defined limits. The privileging authority also initiates and makes determinations on clinical adverse actions.

17. Proctor. A clinical peer who has been appointed in writing to supervise some or all of a health care provider's privileges or practice and is required in order for the provider to proceed in exercising designated privileges or practice. The proctor provides direct oversight of designated clinical activities and must co-sign all such documentation conducted by the provider.

18. Professional Misconduct. Unprofessional, unethical, or other conduct by a health care provider which adversely affects or could adversely affect the health or welfare of a patient or the delivery of health care.

19. Quality Health Care. The degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Care that is evidence-based and provided in a technically and culturally competent manner with good communication and shared decision making.

20. Reduction of Clinical Privilege(s) or Practice. The permanent removal of a portion of a health care provider's clinical privilege(s) or practice as a result of a professional review action following appropriate due process proceedings as described in this instruction. Reduction of privileges is reportable to the NPDB. Reduction of practice is reportable to the appropriate licensing or regulatory agencies.

21. Reinstatement of Clinical Privilege(s) or Practice. The return of clinical privilege(s) or practice as a result of a professional review action following appropriate due process proceedings that may or may not include a FPPE or a period of monitoring and evaluation. Reinstatement following the summary suspension of clinical privileges that was previously reported to the NPDB requires a Revision-to-Action Report to the NPDB.

22. Report Authority. The official with responsibility to report to the NPDB, state(s) of licensure, and other certifying or regulatory agencies following appropriate due process proceedings. Chief, BUMED is the DON Report Authority for matters arising from acts or omissions of health care providers privileged or practicing under Chief, BUMED authority.

23. Restriction of Clinical Privilege(s) or Practice. A temporary or permanent limit placed on all or a portion of a health care provider's clinical privilege(s) or practice as a result of a professional review action following appropriate due process proceedings as described in this instruction. Restricted privilege(s) or practice require supervision by a proctor. Restriction of privileges is reportable to the NPDB. Restriction of practice is reportable to the appropriate licensing or regulatory agencies.

24. Revocation of Clinical Privilege(s) or Practice. The permanent removal of all of a healthcare provider's privileges or practice as a result of a professional review action following appropriate due process proceedings as described in this instruction. Revocation of privileges is reportable to the NPDB. Revocation of practice is reportable to the appropriate licensing or regulatory agencies.

25. Standard of Care. Healthcare judgments and actions of a health care provider generally accepted in the discipline or specialty involved as reasonable and appropriate.

26. Summary Suspension of Clinical Privilege(s) or Practice. The temporary removal of all or a portion of a healthcare provider's privileges or practice that is taken when the clinical adverse action process is initiated. A summary suspension continues until due process procedures are completed. Summary suspensions of clinical privileges that last longer than 30 calendar days must be reported to the NPDB.

PRIVILEGING AUTHORITY INITIAL ACTION

1. Upon discovery or notification of suspected health care provider incompetence, misconduct or any other professional conduct which adversely affects or could adversely affect the health or welfare of a patient or the delivery of health care, the appropriate Privileging Authority must:

a. Consult with BUMED Associate Counsel for guidance on the procedures in this instruction.

b. Determine whether the alleged competency concern or conduct requires immediate action to protect patient safety and, if warranted, remove the individual from clinical practice by placing clinical privileges or practice in summary suspension.

(1) A Privileging Authority may put all or a portion of a health care provider's privileges or practice into summary suspension. The health care provider will be notified in writing and the letter will state the basis for the summary suspension, the privileges or practice affected, and that a quality assurance investigation (QAI) will be conducted. Summary suspension is temporary and remains in effect during the clinical adverse action process.

(2) Any permission for the individual to engage in clinically related off-duty employment must be withdrawn from the initiation of summary suspension until all due process procedures are completed.

(3) Summary suspension of clinical privileges lasting longer than 30 calendar days are reported to the NPDB, state(s) of licensure, and other applicable professional organizations by Chief, BUMED,

c. Coordinate with appropriate Privileging Authority in cases in which a health care provider is practicing or privileged under more than one authority to determine which Privileging Authority is responsible for a comprehensive review of the entire matter.

d. If the alleged competency concern or conduct indicates there is no significant risk to patient safety, the health care provider may remain in clinical practice with placement on a standard of care (SOC) FPPE with monitoring and evaluation for patient safety.

e. If the health care provider's performance under the SOC FPPE heightens concerns for patient safety, the Privileging Authority will place the provider's privileges or practice in summary suspension and initiate due process procedures as described in this instruction.

f. Inquire into or investigate any allegations as described above, without delay. Prompt action is necessary to safeguard patient welfare and protect health care provider rights.

(1) Coordinate, as needed, with Naval Medical Forces Atlantic or Naval Medical Forces Pacific, The Medical Officer of the Marine Corps, or BUMED-N10G to identify the appropriate clinical peer to conduct the QAI. The investigating officer (IO) must be an impartial peer of the provider under investigation with similar privileges or practice, training, and experience and who does not have a personal or professional conflict of interest related to the investigation. The Privileging Authority may also appoint a co-IO to provide administrative support.

(2) Consult with BUMED Associate Counsel to determine the scope of the QAI and to review the appointing letter prior to issuance.

(3) Ensure the IO follows the QAI requirements in enclosure (3) and the legal advice by the assigned BUMED Associate Counsel.

2. All reasonable effort will be taken to protect the identity of persons who offer information that may result in a clinical adverse action taken against a health care provider. For example, the name of the person providing information will be protected unless the due process rights of the health care provider under professional review requires disclosure, or if the disclosure is deemed appropriate pursuant to the Freedom of Information Act or Privacy Act. For this reason, the names of witnesses who provide information during the QAI are initially redacted the first time the health care provider receives a copy of the QAI report. No disciplinary action, punishment, or any form of retaliatory action will be taken against a person who submits information concerning a health care provider unless it is later determined that the person engaged in misconduct or that the person knew the information was false.

3. Criminal investigations (e.g., drug offenses, physical or sexual abuse of a patient, theft of government property, fraud, etc.), command investigations, and inspector general (IG) investigations may be initiated concurrently with a QAI. The QAI should not conflict or interfere with a criminal investigation conducted by Naval Criminal Investigative Service (NCIS), especially when seeking to obtain witness interviews or statements. However, in the interim, the QAI IO is still permitted to review documents relevant to the allegations such as patient medical records or provider prescribing history, the subject provider's credentials file, and any health care policies or procedures.

a. The Privileging Authority, or QAI IO, should coordinate with the assigned NCIS Agent and the health care provider's command Staff Judge Advocate on how and when the QAI can be completed. Witness statements obtained by NCIS may be included in the QAI.

b. When the allegations against a healthcare provider involve misconduct that is also the subject of criminal investigation and possible prosecution, it is permissible to delay the processing of the clinical adverse action pending completion of the criminal case. If the QAI or clinical adverse action process is delayed due to a concurrent criminal investigation and or resolution of pending criminal offenses, the Privileging Authority will notify the subject provider of the delay in writing. A provider's privileges remain in summary suspension during this time.

c. When the criminal investigation and disposition of any charges are completed, documentation from those actions, command investigations and IG investigations, may be included in the QAI or made an addendum to a completed QAI.

QUALITY ASSURANCE INVESTIGATION PROCEDURES

1. A quality assurance investigation (QAI) is initiated at the discretion of the Privileging Authority to examine allegations of clinical incompetence, misconduct, or other professional conduct which adversely affects or could adversely affect the health or welfare of a patient or the delivery of health care. The procedures for conducting a QAI are:

a. The Privileging Authority appoints an investigating officer (IO) in writing. The QAI IO must be an appropriate peer with similar clinical privileges or practice, clinical specialty, and level of training to the provider under review. The purpose and scope of the QAI will be stated in the written appointing letter. The assigned BUMED Associate Counsel must review the appointment letter before it is issued to the IO.

b. The QAI IO must be impartial and have no personal or professional conflict of interest related to the investigation. If the QAI IO is a member of the medical or nursing executive committee or credentials review committee, they are disqualified from any formal committee vote on the case. If appropriate, an IO can be appointed from outside the command.

c. Conducting the QAI is the IO's sole duty and is so stated in the appointment letter. The letter will also provide the IO with the date by which the QAI must be completed; the Privileging Authority may grant an extension if needed. In cases involving the summary suspension of clinical privileges, the QAI completion date should take into consideration an opportunity to evaluate the case and afford an ability to reinstate privileges, if warranted, within 30 calendar days.

d. The IO must consult with and follow the guidance of the assigned BUMED Associate Counsel before beginning and during his or her investigation in order to receive instruction on how to conduct the investigation and direction on the format for the investigative report. The IO is not permitted to complete the QAI independent of the assigned BUMED Associate counsel.

e. The IO should also consult with the medical staff professional (MSP) for the Privileging Authority to receive guidance and or assistance in obtaining documents relevant to the QAI.

f. The IO must collect relevant facts, interview witnesses, review and preserve documentation and other evidence, and make findings as to whether the allegations are substantiated or unsubstantiated. Completed command or legal investigations related to the allegations under review should be included in the QAI. The results of concurrent or previous peer review activities (e.g., FPPEs, Monitoring and Evaluation, QAIs, summary suspensions, etc.) may be included in the report to demonstrate history of clinical practice if relevant to the provider's privileges or practice. However, previously concluded peer review actions may not be used as evidence to substantiate current allegations under investigation. Nevertheless, such information may be relied upon in making recommendations on privileging or practice actions with respect to the likelihood of success of additional remediation efforts.

g. Any medical records reviewed by the IO as part of the QAI must be made an enclosure to the report and will include a statement in the QAI report on how the records were selected for review (e.g., if randomly selected, describe the steps taken to get the resultant records).

h. In QAIs where the subject provider's privileges or practice have not been placed in summary suspension, the IO must immediately inform the Privileging Authority of any information or evidence discovered in the course of investigation that raises concerns about the provider's ability to continue to be involved in direct patient care. Such new information requires a decision by the Privileging Authority to place privileges or practice in summary suspension.

i. The IO may be asked to provide additional information, respond to questions from the reviewing ad hoc medical executive or credentials review committee members or testify at a peer review hearing. Requests for the IO to provide additional information or investigation will be submitted in writing to the Privileging Authority who appointed the IO and, along with any responses from the IO, will be made an addendum to the QAI.

2. The format or template for the QAI will be provided by the assigned BUMED Associate Counsel. The QAI report must contain:

a. A preliminary statement describing the education, training, clinical specialty and experience of the IO; the scope of the investigation (i.e., what allegations and evidence was reviewed and how medical records were selected for review, if applicable); and any difficulties in completing the investigation or obtaining information.

b. A summary of the education, training, clinical specialty, and experience of the health care provider under investigation. Specific detail should include when he or she began working in the current assignment, results of performance evaluations, and origin of the allegations under investigation.

c. A separate statement for each allegation with a recitation of relevant facts and an analysis of the evidence related to that allegation. Based on the evidence discovered during the investigation, an IO may amend, or add to, the allegations investigated but clearly document such amendments in the report.

d. All relevant documents. If documents or other exhibits are not appended to the report, a complete list of those items and their location must be stated. Documents or other exhibits not appended to the report must be safeguarded to ensure their availability during the peer review process. Of note, in cases of suspected misconduct, the results of legal investigations are to be provided to the IO for inclusion in the QAI.

e. Summarized written witness statements or interviews prepared by the IO and attached to the report. In addition, a list of the names and contact information for all witnesses must also be included.

f. While not required, the IO may inquire whether the provider under review consents to be interviewed.

g. Conclusions for each allegation as to whether the allegation is substantiated or unsubstantiated. The standard for reaching these conclusions is preponderance of the evidence; that is, based upon the evidence, it is more likely than not the allegation is true or untrue.

h. An action recommendation, based on the findings, which is limited to one of the following, as applicable:

(1) Reinstatement of clinical privileges or practice.

(2) Reinstatement of Privileges or Practice with Monitoring and Evaluation (M&E) or Focused Professional Practice Evaluation (FPPE) with M&E plan. M&E and FPPE is distinct from restricted practice as there is no supervision of clinical privileges or practice and it is not a CAA. Privileges or practice reinstated with a documented plan of M&E must include clear expectations and measures of success that will be routinely reviewed throughout the period of M&E.

(3) Restriction of clinical privileges or practice (identify which privileges or areas of practice are affected)

(4) Reduction of clinical privileges or practice (identify which privileges or areas of practice are affected).

(5) Revocation of clinical privileges or practice.

(6) Denial of clinical privilege(s) (only applicable to privileged providers).

i. The following statement at the bottom of every page of the report, "This is a medical quality assurance document, protected pursuant to reference (a), section 1102. Copies of this document, enclosures thereto, and information therefrom will only be released in accordance with the law."

j. The IO will have a draft of his or her report reviewed by the assigned BUMED Associate Counsel to ensure the requirements stated above have been met and that the evidence in the report supports the IO's findings and recommendations. The QAI is incomplete until reviewed by BUMED Associate Counsel and determined to be legally sufficient.

k. The IO will submit the completed written QAI report to the MSP or Privileging Authority designee. The MSP or designee will redact privacy information (e.g., witness names, patient privacy information) from the QAI report, but not the enclosures to the report.

CLINICAL ADVERSE ACTION PROCESS

1. Summary Suspension.

a. Upon decision by the Privileging Authority to place clinical privileges or practice in summary suspension, the provider must be notified in writing. The notice will include: the basis for the action (i.e., allegations of incompetence, misconduct, or other professional conduct that adversely affects or could adversely affect the welfare of a patient or delivery of health care); the initiation of a QAI; the opportunity to review a redacted copy of the completed QAI report (without enclosures) and to submit a written statement in response; the review of the QAI report and statement (if submitted) by an ad hoc medical executive or credentials review committee; the reporting of the summary suspension of clinical privileges to the NPDB and state(s) of licensure if it lasts longer than 30 calendar days; and the requirement to elect in writing the continuation of due process proceedings if the provider' affiliation with the DON ends while privileges or practice are in summary suspension. See enclosure (8) of this instruction for a sample notification letter.

b. If only a portion of the provider's privileges or practice are being placed in summary suspension, the notification letter must state which privileges or practice are affected.

c. The notice of summary suspension must be reviewed by the assigned BUMED Associate Counsel prior to signature by the Privileging Authority.

d. The Privileging Authority will direct that the notice of summary suspension is delivered to the provider in person with acknowledgement of receipt or sent by certified mail or secure electronic transmission with confirmation of receipt.

e. While under summary suspension and during the CAA due process, the health care provider will not be assigned to any clinical duties involving the privileges or practice placed in summary suspension. In addition, providers must not deploy or engage in off-duty employment; these actions must be coordinated with the appropriate command authority. The Privileging Authority must also consider whether to permit the provider continued access to electronic health care records during the CAA process.

f. The Privileging Authority must promptly notify other Privileging Authorities (DoD and civilian) under who the provider holds privileges or practices (i.e., temporary assignments on an ICTB, off-duty employers or civilian facilities if participating in an outside training or skills sustainment agreement).

g. If the provider is a federal civilian service employee, the MSP will provide a copy of the summary suspension letter to the servicing civilian personnel office. If the provider is a contractor, the MSP will provide a copy of the summary suspension letter to the appropriate contracting office or contracting officer representative.

h. Should the summary suspension end within 30 calendar days and the provider's privileges or practice are restored, the provider may still need to disclose they were under investigation depending on the wording of questions on future credentialing, licensing, or employment documents.

i. The summary suspension of a provider' privileges or practice and or being the subject of a QAI may be mentioned in the provider's clinical performance assessments.

j. If the provider's privileges or practice are due to expire while in summary suspension, no renewal action is taken on the affected privileges or practice.

k. The MSP will notify BUMED Associate Counsel (N01L) and provide a copy of the summary suspension notification within 5 calendar days of issuance.

2. Quality Assurance Investigation (QAI). The QAI will be conducted and completed per the guidance in enclosure (3).

3. Provider Opportunity to Review QAI and Submit Statement

a. The provider will be given a redacted copy of the completed QAI report without enclosures for their review and right to submit a statement in response. See enclosure (8) for a sample notice of right to submit a statement in response to QAI. The redacted copy of the QAI report will be delivered to the provider in person with acknowledgement of receipt or sent by certified mail or secure electronic transmission with confirmation of receipt.

b. After receipt of the redacted copy of the QAI report, the provider will have up to 15 calendar days to submit a written statement, if desired, in response to the QAI report.

c. If a statement by the provider is not received within 15 calendar days and no request for an extension of time was made, then the right to submit a statement is waived.

4. Medical Executive or Credentials Review Committee Action

a. The complete unredacted QAI report and provider statement, if submitted, will be forwarded to the Chair, Medical Executive Committee (MEC) or Chair, Credentials Review Committee (CRC), as appropriate, who will appoint an ad hoc committee to meet and review the documents. The ad hoc committee will consist of three providers from either the MEC, CRC or a combination of both as long as they meet the requirements in subparagraphs 4a(1) through 4a(3).

(1) When a privileged provider is under review, the ad hoc committee members will be comprised of privileged providers, with at least 1 member being a peer (similar privileges, practice, specialty, and level of training) to the privileged provider under review. For a non-privileged provider, the MEC or CRC Chair may appoint ad hoc committee members comprised

of non-privileged providers, with at least 1 member being a peer to the non-privileged provider under review. If needed, members of the ad hoc committee may come from outside the command. The ad hoc committee members may participate via video teleconferencing, audio, or in person to meet this requirement.

(2) Personnel participating in the ad hoc committee must be able to impartially review the case. The following personnel will not participate: direct supervisor or subordinates of the provider under review; any IOs; any person whose testimony is relevant to the case; any officer or provider who is or has participated in other proceedings (courts-martial or administrative review boards) involving the provider under review; and any person who is reviewing, or has reviewed, the provider's actions under consideration.

(3) The role of the ad hoc committee is to examine information contained in the QAI and the provider's statement, if submitted, and make findings and recommendations to the Privileging Authority. If additional information is required by the ad hoc committee, they may refer the case back to the IO for further response or inquiry by making a written request to the Privileging Authority.

b. The provider under review does not have the right to attend the meeting of the ad hoc committee. The provider may consult with legal counsel at their expense (active duty Service Members may be able to receive representation from Navy uniformed counsel consistent with Navy Judge Advocate General instructions) at any step in this process. However, the ad hoc committee meeting is not a legal proceeding, and no rights are afforded outside of this instruction.

c. The chair of the ad hoc committee will forward to the Privileging Authority, via the assigned BUMED Associate Counsel, a written action recommendation report within 10 calendar days of review completion. See enclosure (8) of this instruction for a sample credentials committee recommendation report. The report will include supporting comments and analysis and will be limited to one of the listed recommendations:

(1) Reinstatement of Privileges or Practice.

(2) Reinstatement of Privileges or Practice with Monitoring and Evaluation (M&E) or Focused Professional Practice Evaluation (FPPE) with M&E plan. M&E and FPPE is distinct from restricted practice as there is no supervision of clinical privileges or practice and it is not a CAA. Privileges or practice reinstated with a documented plan of M&E must include clear expectations and measures of success that will be routinely reviewed throughout the period of M&E.

(3) Restriction of clinical privileges or practice (identify which privileges or areas of practice are affected)

(4) Reduction of clinical privileges or practice (identify which privileges or areas of practice are affected).

(5) Revocation of clinical privileges or practice.

(6) Denial of clinical privilege(s) (only applicable to privileged providers).

5. Initial Legal Sufficiency Review. Upon receipt of the ad hoc credentials committee recommendation report, the assigned BUMED Associate Counsel will complete a legal sufficiency review of the case and provide a written memorandum to the Privileging Authority

6. Privileging Authority Proposed Decision

a. The Privileging Authority has 10 calendar days from receipt of the ad hoc committee recommendation report and legal sufficiency review to give written notification to the provider of their proposed decision and basis for action. See enclosure (8) for a sample proposed decision letter. The Privileging Authority is not bound by the recommendations of the ad hoc committee. Action different from the ad hoc committee recommendations require written explanation in the notice of proposed decision.

b. The proposed decision letter must be reviewed by the assigned BUMED Associate Counsel prior to signature by the Privileging Authority.

c. If the decision is to reinstate clinical privileges or practice, with or without FPPE and M&E, the decision is final and no further due process is required. The Privileging Authority will direct the notice of reinstatement of clinical privileges or practice is delivered to the provider in person with acknowledgement of receipt or sent by certified mail or secure electronic transmission with confirmation of receipt.

(1) If FPPE and M&E are required, the Privileging Authority will provide information on the monitoring and evaluation plan by separate correspondence.

(2) The Privileging Authority must promptly notify other Privileging Authorities (DoD and civilian) under who the provider holds privileges or practices of the decision to reinstate clinical privileges or practice (off-duty employers or if participating in an outside training or skills sustainment agreement).

(3) If the provider is a federal civilian service employee, the MSP will provide a copy of the reinstatement of privileges or practice letter to the servicing civilian personnel office. If the provider is a contractor, the MSP will provide a copy of the reinstatement of privileges or practice letter to the appropriate contracting office or contracting officer representative.

(4) If privileges or practice are reinstated with FPPE and M&E, but the provider is no longer assigned to the Privileging Authority or affiliated with the DON, the Privileging Authority

will include in the decision letter any substantiated findings and state that such findings will be included in an amended closed out or detaching clinical performance evaluation. See enclosure (8) for a sample notice of reinstatement letter. This information will be relied upon in responding to future credentialing, licensing or employer queries regarding the provider. A copy of the amended evaluation will be sent to the provider via certified mail or secure electronic transmission.

(5) If a provider ends affiliation with the DON while under a FPPE monitoring and evaluation plan, the Privileging Authority will determine based on recommendation from the MEC or CRC whether the provider satisfactorily completed the plan or not and note that determination in the provider's detaching clinical evaluation. This information will be relied upon in responding to future credentialing, licensing or employer queries regarding the provider.

d. If the proposed decision is a restriction of privileges or practice, the Privileging Authority will include in the decision letter the conditions and requirements (including any specified time duration of the restriction) that must be met prior to reinstatement of privileges or practice.

e. Any proposed decision to restrict, reduce, revoke or deny (only applicable for a privileged provider) a provider's privileges or practice, the privileging authority must advise the provider in writing of their right to a request a peer review hearing and appeal rights.

(1) Notification of the proposed adverse decision will be delivered to the provider in person with acknowledgement of receipt or sent by certified mail or secure electronic transmission with confirmation of receipt.

(2) The notice of proposed adverse decision will include a copy of the redacted QAI report without enclosures, the provider's statement (if submitted), and a copy of the ad hoc committee's recommendation report.

f. The MSP will notify and provide a copy of the Privileging Authority's written proposed decision to BUMED Associate Counsel (N01L) within 5 calendar days of issuance. If the provider is a federal civilian service employee, the MSP will provide a copy of the written proposed decision to the servicing civilian personnel office. If the provider is a contractor, the MSP will provide a copy of the written proposed decision to the appropriate contracting office or contracting officer representative.

7. Provider Peer Review Hearing Rights

a. If the Privileging Authority's proposed decision is adverse, the provider may elect a peer review hearing; an election must be made in writing within 30 calendar days after receipt of the proposed adverse decision. The Privileging Authority may extend this time period as appropriate.

(1) If the provider waives their right to a peer review hearing, the right to appeal is also waived. If no written request from the provider is received within the allotted time, the hearing and appeal rights are waived. In both situations, the proposed decision will then become final.

(2) If the provider has waived their right to a peer review hearing, the Privileging Authority will issue a written final decision to the provider indicating the waiver of their rights. See enclosure (8) for a sample notice of final decision letter without hearing. The Privileging Authority will then prepare a memorandum to Chief, BUMED and include the complete peer review record that will be forwarded to BUMED for review and reporting of the action to the NPDB and appropriate agencies.

b. If the provider elects a peer review hearing and is no longer assigned to the Privileging Authority or is no longer affiliated with DON, video or telephone conferencing will be provided and is sufficient for due process. The provider may attend the peer review hearing in person, but the Privileging Authority is not responsible for funding the travel.

c. If the provider requested a hearing but fails to appear for the scheduled hearing, the Privileging Authority may choose to proceed with the hearing or consider the hearing waived and act on the provider's privileges as stated in the written notice of the proposed decision. The appeal rights are also considered waived.

8. Peer Review Hearing Notification

a. If elected, the hearing date will not be less than 30 days and not longer than 90 days after receipt of the provider's request for a hearing.

(1) The Privileging Authority via the MSP should coordinate with the provider on the date(s) for the peer review hearing.

(2) The Privileging Authority may extend the time period for scheduling a peer review hearing date as appropriate.

b. The Privileging Authority will notify the provider in writing of the peer review hearing date(s). See enclosure (8) of this instruction for a sample notice of peer review hearing panel letter. The notice of peer review hearing must be reviewed by the assigned BUMED Associate Counsel prior to signature by the Privileging Authority. The written notice of peer review hearing is issued to the provider as soon as possible but no later than 30 calendar days before the hearing date. The notice must include:

(1) The date, time, and location of the hearing.

(2) A statement of the provider's right to be represented by counsel at their expense or to have another representative present. Active duty Service Members may be able to receive representation from Navy uniformed counsel consistent with Navy Judge Advocate General instructions. Legal counsel or other representative may actively participate in the hearing, address the hearing panel, and question witnesses.

(3) A statement of the provider's right to be present, to submit evidence, to call and cross-examine witnesses, and to make a statement (sworn or unsworn). If the provider is unable to attend the peer review hearing in person, video or telephone conferencing may be used.

(4) The names of witnesses to be called to testify at the peer review hearing and or those witnesses who are on standby to testify if requested by the peer review hearing panel. Witnesses may testify in person, by video or telephone conferencing, or via a written statement. DON is not required to support witness travel costs. Witnesses who are contract employees cannot be compelled to testify at the peer review hearing.

(5) A copy of the documents that will be presented at the peer review hearing to include a complete unredacted copy of the QAI report and all enclosures.

c. The Privileging Authority will ensure the notice of peer review hearing is delivered to the provider in person with acknowledgement of receipt or sent by certified mail or secure electronic transmission with confirmation of receipt.

d. The MSP will notify and provide a copy of the notice of peer review hearing panel to BUMED-N01L within 5 calendar days of issuance.

e. The provider will disclose the names of witnesses testifying on their behalf and a copy of the documents they will present at the peer review hearing panel no later than 15 calendar days before the scheduled peer review hearing. Witnesses may testify in person, by video or telephone conferencing, or via a written statement. The provider must arrange for the presence or availability of their witnesses. The failure of witnesses to appear will not constitute procedural error or basis for delay of the proceedings.

f. The provider may request, in writing, a delay of the peer review hearing for good cause. The Privileging Authority may grant a request for a delay. However, if the scheduled hearing is within 5 calendar days, no postponement will be granted by the privileging authority unless there are extenuating circumstances.

9. Convening and Appointment of the Peer Review Hearing Panel

a. The Privileging Authority will convene a peer review hearing panel and appoint members in writing. See enclosure (8) of this instruction for a sample peer review hearing panel

convening order letter. The peer review hearing panel convening order letter must be reviewed by the assigned BUMED Associate Counsel prior to signature by the Privileging Authority. The panel will include a minimum of 3 providers who will be fair and impartial.

(1) For the privileged provider, the peer review hearing panel will include privileged providers, a majority of which will be a peer of the privileged provider under review.

(2) For the non-privileged provider, the peer review hearing panel will include non-privileged providers, a majority of which will be a peer of the non-privileged provider under review.

(3) The peer review hearing panel chairperson will be one of the 3 voting panel members and identified in the appointment letter. The chairperson consults with the appointed legal advisor to ensure compliance with conducting the hearing. In consultation with the legal advisor, the chairperson arranges for the orderly presentation of evidence and rules on the relevance and admissibility of substantive clinical matters.

(4) For civilian providers under review, one member should be a civilian, if available.

(5) For active duty providers under review who belong to a different military service, one member should be from that military service, if available.

(6) To facilitate an impartial peer review hearing panel, the following will not be appointed to the panel: members of the MEC, CRC or ad hoc committee; direct supervisor or subordinates of the provider under review; any IOs; any person whose testimony is relevant to the case; any person who is or has participated in other proceedings (courts-martial or administrative review boards) involving the provider under review; and any person who has reviewed or given an opinion of the provider under review.

(7) The members of the peer review hearing panel may participate in person or participate remotely via video conferencing.

b. A non-voting legal advisor (attorney) will be appointed to the peer review hearing panel in writing to provide procedural and evidentiary guidance to the chairperson. The advisor may participate via video teleconferencing, audio or in person.

(1) The legal advisor supports the chairperson, and any consultations are permitted to be off the record and outside the presence of the provider, provider's counsel or representative, and the Privileging Authority's representative.

(2) The legal advisor may administer oaths to the peer review hearing panel members and witnesses.

(3) legal advisor advises the Privileging Authority on ruling on any challenges made to the peer review hearing panel chairperson.

(4)The legal advisor may be a uniformed attorney from any service, DoD or DON general counsel, or BUMED Associate Counsel who is not advising the privileging authority or Chief, BUMED on the subject case.

c. A non-voting representative for the Privileging Authority will be appointed to the peer review hearing panel to present evidence to the hearing panel and administer oaths or affirmation to witnesses called to testify. The representative will be a federal employee (military or civilian). The MSP will assist the representative in preparing evidentiary packets and exhibits for the hearing panel and the provider's counsel and may seek additional guidance from the assigned BUMED Associate Counsel. The representative also assists the peer review hearing panel in obtaining factual information related to the allegations under review. As such, the representative may make opening and closing remarks, address the hearing panel, respond to comments made by provider's counsel, and question witnesses.

10. Transcript of the Peer Review Hearing Panel

a. The Privileging Authority via the MSP and assigned BUMED Associate Counsel will arrange for a verbatim transcript of the peer review hearing procedures, with exhibit items listed and numbered as they are presented. Court reporters may be used from the base legal office, if available; however, obtaining court reporting services is at the cost of the provider's command or BUMED, as appropriate.

b. The peer review hearing transcript is protected as a medical quality assurance record per reference (a), section 1102.

c. The peer review hearing transcript (paper or electronic) must be completed no later than 30 calendar days from the completion of the peer review hearing to the extent practicable. One original and one copy of the transcript are prepared. The court reporter may provide the transcript and exhibits in electronic form.

d. The hearing transcript must be authenticated by the chairperson of the hearing panel.

11. Peer Review Hearing Panel Procedures

a. The peer review hearing is a closed and confidential peer review proceeding.

b. The peer review hearing is an administrative proceeding and the rules of evidence for courts-martial and other judicial proceedings do not apply. Oral and written matter that is not admissible in a court of law may be considered by the hearing panel subject only to reasonable restrictions on relevance, materiality, competence, and cumulativeness.

c. The burden of proof for the peer review hearing is preponderance of the evidence, which means the greater weight of credible evidence or that the factual allegation is more likely than not true or untrue. There is no requirement to prove any allegation beyond a reasonable doubt.

d. The provider may challenge any voting peer review hearing panel member for cause; that is, by showing a member cannot render a fair, impartial decision. Cause for removal of a member exists if a member has a predisposed attitude toward the outcome of the hearing. Mere knowledge of the facts of a case is not sufficient cause for removal. The chairperson of the peer review hearing panel rules on a challenge to a peer review hearing member; the Privileging Authority rules on a challenge to the chairperson.

e. An witness who is reasonably available and whose testimony will add materially to the issues before the hearing panel may be invited to appear in person. This includes the QAI IO and the provider's clinical supervisors.

(1) Witnesses not within the immediate geographic area of the site of the hearing are not reasonably available for personal appearance, witnesses who are unable to appear in person or participate in telephonic or video conferencing may submit written statements.

(2) Witnesses outside the provider's command whose appearance at the peer review hearing is considered material to the proceedings may be requested, at the discretion of the Privileging Authority, from the witness's command or activity head. The commanding officer or activity head of an active duty Service member or DON civilian determines whether the requested witness will be permitted to attend the hearing in person, telephonically or virtually.

(3) Witnesses not on active duty or not employed by the DON (i.e., contract employees) appear or participate voluntarily; they cannot be directed or compelled to appear.

f. A sample peer review hearing script is provided in enclosure (5) to serve as an aid in conducting the peer review hearing panel proceeding.

12. Peer Review Hearing Panel Findings and Recommendations

a. At the close of the presentation of all the evidence and closing statements, the peer review hearing concludes, and the panel deliberates off the record.

(1) The peer review hearing panel makes findings, by a majority vote, on each allegation as stated in the notice of peer review hearing letter; they cannot deviate from the wording of the stated allegations or propose additional allegations with findings.

(2) Substantiated allegations must be supported by sufficient credible evidence.

(3) The panel will also provide their rationale for any allegations that are found to be unsubstantiated.

b. Based on their findings, the peer review hearing panel makes a recommendation, by majority vote, to the Privileging Authority regarding the provider's clinical privileges or practice.

(1) The panel is not bound by the Privileging Authority's proposed adverse decision. The peer review hearing panel is permitted to make any recommendation on clinical privileges or practice to include: reinstatement (with or without M&E or FPPE with M&E), restriction, reduction, revocation or denial (applicable only to privileged providers).

(2) The panel's recommended action(s) is based upon prevailing professional standards and on the findings and conclusions from the evidence in the peer review record.

(3) Any proposed limitation, supervision, or other restriction on clinical privileges or practice is inconsistent with a recommendation to reinstate privileges or practice.

c. The peer review hearing panel will provide a written report of their findings and recommendation(s) for action to the Privileging Authority within 30 calendar days of hearing completion.

(1) The report will reference any pertinent section of the hearing record or exhibits as needed to support the findings.

(2) If the peer review hearing panel recommend a temporary restriction of privileges or practice, they must include suggested corrective actions, requirements (including any specified time duration of the restriction), or any other conditions for the provider to accomplish prior to reinstatement of privileges or practice.

(3) Any peer review hearing panel member may submit a minority report if they dissent from any aspect of the panel report providing a statement explaining their dissent.

(4) The verbatim transcript and all exhibits considered by the peer review hearing panel must be appended to the report. See enclosure (8) for a sample peer review hearing panel report.

(5) The chairperson for the peer review hearing panel must have a draft of the panel's report reviewed by the non-voting legal advisor to ensure it meets evidentiary and procedural requirements of this instruction prior to issuance. The final peer review hearing panel report will be signed by all members.

d. A copy of the hearing panel report, exhibits, and transcript will be given to the provider within 30 calendar days of hearing completion. The Privileging Authority will direct these documents be delivered to the provider in person with acknowledgement of receipt or sent by certified mail or secure electronic transmission with confirmation of receipt.

e. The provider will have 10 calendar days from receipt of the report to submit a written statement of exceptions, corrections, or other comments to the Privileging Authority. The Privileging Authority may approve requests for an extension of time for good cause and if made before the time limit has expired. See enclosure (8) instructions of this for a sample notice of right to comment on peer review hearing panel report.

f. The MSP will notify and provide a copy of the peer review hearing panel's report to BUMED-N01L within 5 calendar days of the issuance of the report.

13. Final Legal Sufficiency Review. Upon receipt of the peer review hearing panel report, exhibits, transcripts and written statement from the provider (if submitted), the assigned BUMED Associate Counsel will complete a final legal sufficiency review of the case and provide a written memorandum to the Privileging Authority.

14. Privileging Authority Final Decision

a. The Privileging Authority will make a final decision within 10 calendar days of receipt of the peer review hearing panel report, exhibits, transcripts, written statement from the provider (if submitted), and the final legal sufficiency memorandum.

(1) The Privileging Authority must not consider information outside the peer review hearing record in reaching a final decision.

(2) In reaching a decision, the Privileging Authority is not bound by the peer review hearing panel's findings and recommendation(s). However, the Privileging Authority must provide a rationale for taking a different action and cite to information from the peer review hearing record to support the decision.

(3) The Privileging Authority will provide written notification to the provider of the decision on their privileges or practice and the basis (allegation findings) for such action. If the decision is adverse (restriction, reduction, revocation, or denial), the notice will state the action is reportable to the NPDB (for privileged providers only), state(s) of licensure and other applicable regulatory or professional agencies. The provider will also be informed of their right to appeal the adverse decision to Chief, BUMED. See enclosure (8) of this instruction for a sample final decision letter.

(4) The final decision letter must be reviewed by the assigned BUMED Associate Counsel prior to Privileging Authority signature.

(5) The Privileging Authority's decision is effective immediately and the adversely affected privileges or practice are modified by the MSP per the decision.

(6) The Privileging Authority will direct the final decision letter is delivered to the provider in person with acknowledgement of receipt or sent by certified mail or secure electronic transmission with confirmation of receipt.

b. The MSP will notify and provide a copy of the Privileging Authority's final decision to BUMED-N01L within 5 calendar days of issuance. If the provider is a Federal civilian service employee, the MSP will provide a copy of the written final decision to the servicing civilian personnel office. If the provider is a contractor, the MSP will provide a copy of the written final decision to the appropriate contracting office or contracting officer representative.

c. If a provider waives their right to appeal the final decision, either in writing or by failing to appeal in a timely manner, the Privileging Authority will prepare a memorandum to Chief, BUMED stating the final decision in the case, the provider's waiver of or failure to submit an appeal, and the recommendation that the final adverse action be reported to the appropriate entities. Included with the endorsement, the Privileging Authority will ensure the entire peer review record is sent via secured electronic delivery (i.e., DoD SAFE) to BUMED-N01L. See enclosure (8) of this instruction for a sample forwarding endorsement of non-appeal clinical adverse action.

15. Chief, BUMED Reporting of Clinical Adverse Actions

a. All final clinical adverse actions will be reported by BUMED:

(1) Adverse privileging actions will be reported to the NPDB, state(s) of licensure, professional entities, and entered in the DoD electronic database (i.e., Centralized Credentials and Quality Assurance System (CCQAS)). NPDB reports will be made consistent with NPDB regulations and guidelines and submitted within 30 calendar days of Chief, BUMED approval of the action.

(2) Adverse practice actions will be reported to the appropriate licensing, certifying or registration agency, professional entities, and the DoD electronic database (i.e., CCQAS).

(3) Reports concerning deceased providers must be submitted to the NPDB to prevent identity theft of the deceased provider.

b. Requests for official information regarding pending or final clinical adverse actions from state licensing boards, civilian medical facilities, credentialing agencies, or other entities will be replied to by BUMED N10G or BUMED-N01L after the action is completed and reported, as appropriate.

PEER REVIEW HEARING SCRIPT

1. The following abbreviations are used throughout this guide:

   CHRP: Chairperson
   PA REP: Privileging Authority Representative
   CR: Counsel for Respondent (Provider)
   RESP: Respondent (Provider)
   WIT: Witness

CHRP: This hearing will come to order.

[Please Note: The Chairperson should record the time and date of the opening and closing of each session of the peer review hearing panel and the presence (or absence) of all parties (Peer Review Hearing Panel members, PA representative, Respondent/Provider, counsel for the Respondent/Provider, or other representative.]

CHRP: This peer review hearing is a Medical Quality Assurance Program proceeding under Title 10 United States Code Section 1102, and subject to the protections therein. All records and testimony considered by and given during this peer review hearing must remain confidential and further disclosure may be made only as authorized by law and with the approval consistent with Bureau of Medicine and Surgery Instruction 6010.31A. The prohibition on secondary disclosure extends to any person or entity having possession of, or access to, quality assurance records or testimony.

This peer review hearing has been convened by [**Rank, Name, Corps, USN**], Privileging Authority for [**Name of Organization**], letter of [**Date**], a copy of which has previously been provided to all parties who are present. A copy of the hearing appointing letter will be entered as Exhibit 1.

CHRP: The following persons are present:

_____, Chairperson

_____, Member

_____, Member

_____, Privileging Authority Representative

_____, Respondent

_____, Counsel [or Representative] for Respondent

CHRP: This hearing has been convened for the purpose of reviewing the Privileging Authority's proposed action to [**SPECIFY ACTION**: **restrict, reduce, revoke, or deny**] the [**privileges, practice**] of [**Rank or Title, Provider Name**]. In response to [**Rank or Title, Provider Name**] request for a hearing, a Notice of Peer Review Hearing Panel was issued. A copy of this letter will be entered as Exhibit 2.

CHRP: [**Rank or Title, Provider Name**] I will now discuss with you your rights in connection with this hearing. If you have any questions about any of these rights, do not hesitate to ask me. If you wish, you may discuss your questions with your (counsel or representative).

Exhibit 2, [**Rank, Name, Corps, USN**], Privileging Authority for [**Name of Organization**], letter of [**Date**], provided you notice of this hearing and your advice of rights. BUMED Instruction 6010.31A provides 30 calendar days must elapse between the time you received hearing notification and when the hearing starts unless you agree to an earlier date. This is to ensure you have ample opportunity to prepare your case to respond to the allegations. (As applicable: (You were given a copy of Exhibit 2 more than 30 days ago. The hearing may proceed.) or (You were given a copy of Exhibit 2 less than 30 days ago. The hearing may not start before (date) unless you agree. Do you wish to waive your right to the full 30-day period and proceed now or do you prefer to reschedule the hearing to start (date)?)

First, you have the right to be present at this hearing with or without counsel or personal representative. If you are represented, your counsel or personal representative may actively participate in the hearing and directly address this peer review panel on your behalf.

Second, you have the right to challenge any voting member of this hearing panel for cause; that is, by showing a member cannot render a fair, impartial decision. Cause for removal of a member exists if a member has a predisposed attitude toward the outcome of the hearing. Mere knowledge of the facts of a case is not sufficient cause for removal. You or your representative may question any panel member, including me, to determine whether a basis for challenge exists.

Third, you may examine any and all documentary evidence available to the hearing panel that has a bearing on any matter relevant to this hearing. In this regard, I want to advise you that BUMED Instruction 6010.31A the instruction establishing the hearing process states you will be provided the following at least 30 calendar days before the hearing date:

1. Written notice of the specific date, time, and place of the hearing.

2. Any documentary evidence concerning the allegations against you to be considered at the hearing.

3. Names of witnesses to be called to testify at the hearing.
Did you receive this information at least 30 calendar days before the hearing?

[**Note**: If respondent did not, the reason for the delay in providing the information should be stated for the record and the following stated: Since you did not receive all of the above information in a timely manner, you have a right to request delay of the hearing until (date). Do you wish to proceed with the hearing today or wish to instead start the hearing on (date)? Any information not previously made available to you will now be provided.]

Fourth, you may choose to testify under oath, to make an unsworn statement, and/or to remain silent. If you choose to testify under oath, you will be subject to questioning by the Privileging Authority Representative and the hearing panel members, including me. You may make an unsworn statement orally or in writing, personally or through your representative, or you may use any combination. If you choose to make an unsworn statement, you may not be asked any questions by the Privileging Authority representative or the hearing panel members. If you choose not to testify, that fact cannot and will not be held against you in any way.

Fifth, you have the right to call witnesses on your behalf, but you are responsible for arranging their presence; failure of such witnesses to appear will not constitute a procedural error or basis for delay of the proceedings.

Sixth, you have the right to submit documentary evidence you wish the peer review hearing panel to consider. This includes, but is not limited to, depositions, sworn or unsworn statements, affidavits, and stipulations. This also includes written statements or telephonic testimony of witnesses not reasonably available to appear at the hearing and other witnesses unwilling to appear voluntarily. BUMED Instruction 6010.31A required you to disclose the names and contact information for all witnesses testifying on your behalf and any documentary evidence you wanted the peer review hearing panel to consider at least 15 calendar days before the hearing. I may, upon a showing of good cause, allow you to introduce information to this panel you did not previously disclose; however, I will also consider granting reasonable delay to allow other documents or witnesses to be located and made available to the peer review hearing panel if relevant to address issues or matters your evidence raises.

Finally, your failure to invoke any of these rights is not a bar to the hearing proceedings or to its findings and recommendations.

[**Rank or Title, Provider Name**], do you understand the purpose of this peer review hearing and your rights before it?

RESP/CR: (Questions or the respondent has no questions)

CHRP: I will now review the procedures outlined in BUMED Instruction 6010.31A that will be followed in this peer review hearing.

First, these proceedings are administrative in nature and are not bound by formal rules of evidence. The hearing members may consider information that might not be admissible in a

court of law, so long as the information is relevant to matters before this hearing panel. Each party has the right to present evidence and question witnesses. Members of the hearing panel may ask for additional evidence, summon additional witnesses to testify, and question witnesses who testifies at this hearing.

Second, if any party objects to witnesses, questions, or evidence, or any of the proceedings of the peer review hearing panel, please state the objection and the reasons for it. I will consult with [**name of attorney**], the Legal Advisor appointed to this hearing, as needed prior to ruling on any objections. As Chairperson, I will make the final ruling regarding the relevance and admissibility of substantive clinical matters, and I will defer to the Legal Advisor on procedural matters and issues implicating due process. By the term "relevant evidence", I mean testimony and evidence which will help the peer review hearing panel members make findings and recommendations on the allegations contained in Exhibit 2, the Notice of Peer Review Hearing letter.

Third, the Privileging Authority Representative, or Legal Advisor, will administer oaths or affirmations to the witnesses.

Fourth, the peer review hearing panel's findings must be supported by a preponderance of the evidence. The term "preponderance of the evidence" means the greater weight of credible evidence or that the factual allegation is more likely than not true or untrue. There is no requirement to prove any allegation by beyond a reasonable doubt. The members of the peer review hearing panel will use their best judgment, experience and common sense in resolving disputed and conflicting evidence. The hearing panel's recommendations must be supported by the findings. The recommended action(s) must be by majority vote, made in good faith, and supported by the evidence.

Fifth, if you desire a postponement or continuance of this hearing, you must submit your request to the privileging authority via this panel. Your request may be granted only upon a showing of good cause.

Do you have any questions concerning the procedures before this panel?

RESP/CR: ((Questions) or (The respondent has no questions.))

PA REP: I will now swear in the members of the Peer Review Hearing Panel. Please stand and raise your right hand:

"Do you swear that you will answer truthfully the questions concerning whether you should serve as a member on this hearing panel and that you will faithfully and impartially make findings and recommendations according to the evidence and the stated procedures?"

(Panel members' responses)

PA REP: Peer Review Hearing members, I will now ask you a few questions that will help determine whether you can be fair and impartial at this hearing. Please respond to my questions by stating yes or no.

1. Is any member the supervisor, reporting official or endorsing official on performance evaluations for any member of the peer review hearing panel, for any witnesses expected to testify, or for [**Rank or Title, Provider Name**]?

2. Has any member been asked for or given advice on the allegations being considered in this case or is a principal witness in these allegations?

3. Has any member participated in any other judicial or administrative proceedings regarding [**Rank or Title, Provider Name**]?

4. Is any member aware of any matter which would prevent him or her from rendering an objective, independent, fair, and impartial decision based only on the evidence presented at this hearing?

(Panel members' response(s))

CHRP: At this time, do you or your representative wish to question any voting member of this hearing panel in relation to any matter that may constitute grounds for challenging the member?

RESP/CR: ((Questions) or (The respondent has no questions.))

CHRP: Do you or your representative have any challenge to any voting member of the hearing panel?

RESP/CR: ((Challenge(s) or (The respondent has no challenge(s).))

[**Note**: The Chairman rules on any challenges to a voting member; if the Chairman is challenged, the Privileging Authority must be informed and rule on whether the Chairman can remain on the hearing panel.]

CHRP: At this time, we will hear from the Privileging Authority Representative who will provide an opening statement regarding the background of this case.

PA REP: (The representative should make a brief statement reviewing the facts and circumstances surrounding this case, to include a recitation of the proposed adverse decision by the Privileging Authority in the subject case.)

CHRP: Does respondent or respondent's representative desire to make an opening statement?

RESP/CR: (Opening Statement).

[**Note**: The opening statement may be made now or before presentation of respondent's case.]

CHRP: At this time, the peer review hearing panel will receive such documents as are pertinent to this hearing.

[**Note**: Recorder's exhibits are marked by numbers and respondent's exhibits are marked by letters.]

(Exhibit 1 is the Hearing Appointment letter, Exhibit 2 is the Notice of Hearing letter, Exhibit 3 is the Notification of Proposed Adverse Decision; the remaining recorder exhibits will include the Notice of Summary Suspension, the complete QA investigation report with enclosures, the provider's statement in response to the QA investigation report, the ad hoc MEC or CEC recommendations, the Privileging Authority proposed decision, the Notice of Peer Review Hearing Panel letter, any correspondence concerning requests for delays in hearing dates, production of evidence/witnesses and any waiver of any rights by the respondent. Exhibits should also include copies of relevant information from the provider's clinical activity file and individual credentials file (ICF). The last exhibit will be the findings and recommendation worksheet for the Hearing Panel to use during deliberations).

PA REP: The following documents are submitted for the panel's consideration.

Exhibit 1 is the Peer Review Hearing Panel appointment letter.

Exhibit 2 is the Notice of Peer Review Hearing Panel letter

Exhibit 3 ... etc.

Exhibit __ is the Hearing Panel findings and recommendations worksheet.

CHRP: Are there any objections to the hearing panel's consideration of these exhibits?

RESP/CR: ((Objection) or (There is no objection.))

CHRP: Does respondent have any documents wishes the panel to consider?

RESP/CR: The following documents are submitted for the panel's consideration:

Exhibit A is ...

Exhibit B is ... etc.

CHRP: Exhibits 1 through __ and A through __ are accepted and made a part of the hearing record.

[**Note**: The panel may wish to recess at this point to allow all members the opportunity to review the documentary evidence.]

CHRP: The Privileging Authority's Representative will call the first witness.

PA REP: The first witness is _____.

[**Note**: The chairperson is required to order all oral evidence at the hearing be taken under oath or affirmation, with the exception of any unsworn statement offered by the respondent.]

PA REP: (Administering oath or affirmation.) Do you swear (or affirm) the evidence you give in this peer review hearing will be the truth, the whole truth, and nothing but the truth?

WIT: I do.

PA REP: Would you state your rank, rate, or title; name, corps, armed force, and current duty station?

WIT: (Answer).

[**Note**: The Privileging Authority representative should conduct the initial introductory questioning of each witness. Detailed questioning on the medical aspects of the allegations should be done by the panel members. Thereafter, respondent will have an opportunity to question (cross-examine) each witness.]

CHRP: (After questioning is completed.) Thank you for your testimony. You are not to discuss your testimony outside of this peer review hearing. The information and testimony from this peer review hearing is Quality Assurance information gathered specifically for that purpose and as such is protected from release by Title 10 United States Code Section 1102. Unauthorized release could result in a personal fine of $3,000 for a first offense and not more than $20,000 in the case of a subsequent offense. Do you understand? (Witness answers) Do the parties know how to contact this witness in the event further testimony is required? (Response)

[Note: After all witnesses desired by the Privileging Authority representative and peer review panel members have testified, respondent is permitted to present testimony of witnesses on their behalf. The Privileging Authority Representative administers the oath and conducts initial questioning, followed by questions from the peer review panel members and representative.]

RESP/CR: (At conclusion of witness testimony.) I have nothing further to present.

[**Note**: If the peer review hearing panel now desires additional witnesses, they may be called or recalled at this point.]

CHRP: Does the representative or respondent want to make a brief closing statement?

PA REP/RESP/CR: Yes/No (sir or ma'am). (Closing Statements).

CHRP: Has the recorder or respondent anything further to offer?

REC/RESP/CR: No, (sir or ma'am).

CHRP: Prior to going into deliberations, I want to revisit on the record the rules that will govern the peer review hearing panel's deliberations and to acknowledge that the guidance in BUMED Instruction 6010.31A will be followed.

To begin, we are not bound by the Privileging Authority's proposed decision in this case. The peer review hearing panel is permitted to make any recommendation in this case to include: reinstatement (with or without monitoring and evaluation or focused professional practice evaluation), restriction, reduction, revocation or denial (applicable only to privileged providers). It is noted, however, that a restriction, reduction, revocation or denial of privileges are adverse actions and if approved by Chief, BUMED, will result in a report of the action to the National Practitioner Data Bank (for privileged providers), to all states of known licensure, and other appropriate regulatory and professional agencies. A restriction, reduction or revocation of clinical practice is an adverse action and if approved by Chief, BUMED, will result in reports to the provider's state(s) of known licensure and other appropriate regulatory and professional agencies.

In determining our findings, we are to apply the preponderance of the evidence standard and to use our best judgment, experience, and common sense in resolving disputed and conflicting evidence.

Based on our findings, we are to make a recommendation, by majority vote and in good faith, to the Privileging Authority regarding [**Rank or Title, Provider Name**] clinical **[privileges, practice**]. Such recommendation will be based upon prevailing professional standards and on the findings and conclusions from the evidence in the peer review record.

Any peer review hearing panel member may submit a minority report if they dissent from any aspect of the peer review panel's findings or recommendations.

The Legal Advisor can assist as needed in the deliberations and with drafting of the panel report to ensuring the findings and recommendations are in proper form. The members may also reopen the hearing to request additional testimony and documents.

[**Rank or Title, Provider Name**], you will be provided a copy of the peer review hearing panel's report and transcripts and given an opportunity to submit a statement before our report is forwarded the Privileging Authority. This hearing is adjourned.

APPEAL PROCESS

1. Appeal of The Privileging Authority's Clinical Adverse Action Decision

a. Each health care provider has the right to written appeal of the Privileging Authority's adverse decision to Chief, BUMED.

(1) The provider must submit a written request to the Privileging Authority no later than 10-calendar days from receipt of the Privileging Authority's final adverse decision.

(2) The provider may request an extension of time to submit an appeal for good cause. Extensions are granted by the Privileging Authority.

(3) The Privileging Authority's final decision remains in effect during the appeal process. However, a revision to action report to the NPDB will not be made until after Chief, BUMED acts on the appeal.

b. The Privileging Authority will have 14 calendar days to provide a written decision to the provider on the appeal. If the Privileging Authority denies (partial or complete) the appeal, the appeal will be promptly forwarded to Chief, BUMED for further review and final decision on the appeal.

(1) In the forwarding endorsement of the appeal to Chief, BUMED the Privileging Authority must respond, comment or offer rebuttal evidence (if applicable) to issues raised in the provider's appeal.

(2) Any delays encountered by the privileging authority must be noted in the forwarding endorsement.

(3) The forwarding endorsement will also provide information on the current military or employment status of the provider and identify any associated administrative actions. This may include information related to special pays, pending administrative discharge or retirement, physical evaluation board, or other employment or contract status.

c. The forwarded peer review record from the Privileging Authority, sent via secure electronic submission, must include:

(1) The full and complete case file to date (the unredacted QAI report with all enclosures; all notices (i.e., summary suspension, provider opportunity to make a statement, proposed decision, notice of peer review hearing, notice of final decision, notice of decision on appeal); legal sufficiency reviews; appointment letters; MEC, CRC or ad hoc committee recommendations; peer review hearing panel report; hearing exhibits; hearing transcripts; written appeal and Privileging Authority decision on appeal; and all other requests or communications with the provider).

(2) The Privileging Authority's forwarding endorsement as described in subparagraph 1b.

2. BUMED Appellate Process

a. Appellate review is based on sufficiency of due process, evidentiary support for the findings, and whether the decision by the privileging authority was an abuse of discretion.

b. BUMED High Reliability Office, Clinical Quality Management (BUMED-N10G) will coordinate the appeal process to include:

(1) BUMED-N01L written legal review of the due process procedures.

(2) Clinical peer review by an appropriate peer.

(3) Review by a Healthcare Professional Appropriate Panel (HPAP) to examine the entire peer review record, provider appeal, legal, and clinical peer review and make a written recommendation on the appeal to Chief, BUMED.

(a) The committee will be comprised of at least three (3) members, to include BUMED's Chief Medical Officer (who will act as the Chair), the Deputy Corps Chief for the respective practice (i.e., Medical Corps, Dental Corps, Nurse Corps, Medical Service Corps, or Hospital Corps) and a Peer with a similar specialty to the provider under review. BUMED General Counsel will assign an attorney to assist the HPAP as a non-voting member.

(b) The HPAP can meet virtually or in person.

(c) The individual under review does not have a right to attend the meeting of the HPAP.

(d) If the individual under review is an active duty member of a different service, a representative from the member's service should be appointed, if available. Copies of all adverse action documents will be sent to the member's Surgeon General's Office for review and comment prior to consideration of the case by the HPAP.

(e) The HPAP will provide a written report with recommendations to Chief, BUMED on whether to grant or deny the appeal and include their analysis of the evidence to support the recommendations.

3. Chief, BUMED Decision

a. Chief, BUMED will make the final decision on whether to grant or deny an appeal. If a procedural error or evidentiary issue is identified during the appellate review and affects the

fundamental fairness of the peer review process, Chief, BUMED, as the appellate authority may modify or overturn the action without returning the case to the Privileging Authority for further due process.

b. The provider will be notified in writing of the final decision on their appeal and the rationale for that decision. The Privileging Authority will be copied on the final decision letter.

c. If the individual is an active duty member of a different service, the member's Surgeon General's Office will be notified of the final decision.

d. The decision by Chief, BUMED is final. Revision to action reports to the NPDB will be made as directed by Chief, BUMED.

REPORTABLE HEALTH CARE RELATED MISCONDUCT

1. Criminal convictions and other administrative actions taken against health care providers or suppliers that are related to the delivery of health care items or services will be reported to the NPDB. Personnel (active duty, civil service and personal service contractors) in any position or assignment providing healthcare items or services, whether in direct patient care or in support of the delivery of healthcare, are subject to reporting. Reporting of health care providers and suppliers is not exclusive to individuals who are licensed, certified, registered, or privileged.

2. Health care related misconduct must also be considered for a potential clinical adverse action when the conduct adversely affects or could adversely affect the welfare of a patient or the delivery of health care. If a clinical adverse action is initiated, the procedures in enclosures (2) through (6) will be followed. It is permissible for the misconduct described in this enclosure to result in separate actions which may result in multiple reports to the NPDB (e.g., adverse privileging action, criminal conviction, and other administrative action).

3. The types of actions subject to reporting include:

a. Uniform Code of Military Justice (UCMJ) Actions. Convictions under reference (a), chapter 47, also known and referred to as "the UCMJ," as approved in the entry of judgment at courts-marital, or final non-judicial punishment, regardless of whether the conviction or punishment is the subject of a pending appeal.

b. Other Adjudicated Actions or Decisions. The following actions are reportable if they are against a health care provider or supplier based on acts or omissions that affect the payment, provision, or delivery of a health care item or service:

(1) Adverse Personnel Actions Affecting Uniformed Service Members. Any administrative action resulting in separation, reduction in grade, involuntary military occupational specialty reclassification, or other administrative action in which the member is given notice, an opportunity to be heard, and an appeal right.

(2) Adverse Civilian Personnel Actions. Any adverse personnel action as described in of reference (g), sections 7501 through 7543, as well as actions under reference (g), chapter 43, when there is a due process proceeding. Resignations in lieu of removal are not reportable, unless related to the delivery of health care.

(3) Certain Contracting Actions. A contract termination for default against a non-personal services or personal services contractor or terminations of personal services contractor employees related to evidence of health care related misconduct.

4. The types of misconduct which must be reported to BUMED-N01L include:

a. Fraud or misrepresentation involving application for initial, active, modification, or renewal of credentials, staff appointment, and privileges. This includes, but is not limited to, failure to disclose any sanction issued by a licensing or regulatory agency in a timely manner (within 7 calendar days), any ongoing investigations by a licensing or regulatory agency, falsifying credentials, forging signatures on peer reference letters, and other intentional acts or omissions meant to deceive the credentialing and privileging process.

b. Theft of government or personal property committed in a clinical setting.

c. Drug offenses to include illegal use, possession or distribution of controlled substances; diversion of narcotics; self-prescribing; or other improper prescribing or use of controlled medications.

d. Reporting to or performing clinical duties (to include being on call or otherwise on duty) while under the influence of alcohol or drugs.

e. Treatment failure for substance use disorder.

f. Unauthorized access to or disclosure of protected health information or other violations of the Heath Insurance Portability and Accountability Act.

g. Acts of sexual abuse, sexual assault, sexual harassment or exploitation.

h. Engagement in a consensual sexual or other inappropriate relationship with a patient that violates professional boundaries.

i. Assault or verbal abuse of patients or staff or engagement in threatening behavior.

j. Other acts or omissions for which the provider is formally disciplined that can be considered related to the delivery of a healthcare item or service.

5. Commanders and commanding officers of Navy health care providers and suppliers, with the assistance of their servicing legal counsel and designated privileging authority, are responsible for identifying administrative or disciplinary actions that meet the criteria in paragraph 2 and forwarding such actions to Chief, BUMED with a recommendation on whether to report the action to the NPDB.

a. The Commander or commanding officer, or his designee, will notify the individual in writing of the effect the misconduct had or could have had on the provision of a healthcare item or service and that the case will be forwarded to Chief, BUMED for final determination and reporting to the NPDB as appropriate. The individual will also be notified that he or she may submit a written statement within fourteen (14) calendar days regarding the recommended reporting of the misconduct. If submitted, this statement will be commented on, and attached to, the forwarding letter to Chief, BUMED.

b. The additional required documentation for inclusion with the report to Chief, BUMED include, as appropriate, the complete criminal case file (i.e., report(s) of investigation, charge sheet, command disposition (non-judicial punishment package or results of courts-martial)), report of misconduct to Navy Personnel Command, or SF 50 Notice of Personnel Action for civilian employees with supporting documentation. The report and supporting documentation should be sent to the attention of BUMED-N01L via secure electronic transmission (i.e., DoD SAFE).

c. The requirement to report these actions to Chief, BUMED applies to all Navy healthcare providers and suppliers including military members (officers and enlisted), Federal civilian employees, and contractors regardless of privileging status or possession of state licenses, certifications or registrations.

6. Chief, BUMED is responsible for reviewing the case file and deciding whether to report the action to the NPDB. Upon direction by Chief, BUMED reports will be made to the NPDB and to state(s) of licensure or other certifying or regulatory agencies, as appropriate.

a. Upon notification to Chief, BUMED that a criminal conviction or other administrative action or decision is overturned or modified on appeal after a report has been made to the NPDB, Chief, BUMED will direct a Revision-to-Action Report or a Void Report (if the action or decision was vacated).

b. Reports involving deceased health care providers must be submitted to the NPDB to prevent a fraudulent provider from assuming the identity of the deceased provider.

c. Criminal convictions or other administrative actions reported to the NPDB will be entered into the DoD electronic database (CCQAS) in the adverse action module.

SAMPLE NOTICE OF SUMMARY SUSPENSION

From: Privileging Authority
To: Provider

Subj: NOTICE OF SUMMARY SUSPENSION

Ref: (a) BUMEDINST 6010.31A

1. Per reference (a), effective immediately, your clinical [privileges or practice] at [location] are in summary suspension as follows: [state what privileges or practice are affected: all or some (if only some state which ones)].

2. This action is being taken in response to allegations of (state the issues involved: incompetence, misconduct, or other professional conduct which adversely affect or could adversely affect, the welfare of a patient or delivery of health care). These issues have had (or could potentially have) the following adverse effects on patient safety and healthcare delivery (describe the possible effects). [If the issues concern a question of conduct implicating professional judgment, include the following statement: The alleged incident raises questions about your professional judgment, which could also call into question your clinical judgment].

3. During this period of summary suspension you are relieved of the following clinical duties [all or note which clinical privileges are affected]. [If a summary suspension is for all clinical privileges or practice, add: You may not participate in any patient care duties nor engage in any other activity directly involving patient contact. If it is a partial summary suspension, add: You may only participate in the following clinical duties: (provide list)]. A summary suspension is a temporary removal of your clinical [privileges or practice] and has been taken while an investigation into the above stated allegations and due process procedures are completed.

4. [For privileged providers only] If the summary suspension lasts longer than 30 calendar days and your privileges have not been reinstated, the action must be reported to the National Practitioner Data Bank (NPDB) and your state(s) of licensure. If the summary suspension is reported to the NPDB, a Revision-to-Action report will be submitted upon completion of your case.

5. You are also notified that a Quality Assurance Investigation (QAI) will be conducted into the allegations specified in this letter. You will receive a redacted copy of the completed report without enclosures and given 15 calendar days to submit a written statement in response to the QAI that will be reviewed by an appointed ad hoc credentials review committee. Your statement may be submitted to [POC and email address]. The ad hoc credentials review committee will meet and review both the QAI report and your statement in order to make a recommendation for a proposed decision on your clinical [privileges or practice] to the Privileging Authority. You do not have the right to attend the ad hoc credentials review committee meeting.

Subj: NOTICE OF SUMMARY SUSPENSION

6. **Providers who separate, resign, retire, are discharged, or end affiliation with the Military Health System (MHS) while under summary suspension may be reported to the NPDB, state licensing agencies, and other regulatory agencies, as appropriate, after the allegations are fully investigated.** You may request the due process review of your clinical [privileges or practice] continue following your separation or end of affiliation with the MHS**. If you desire a continuation of due process, you must submit a request in writing to the Privileging Authority within 5 calendar days following your knowledge of the change in your affiliation status.** If you do not request continuation of due process, the QAI will be completed and forwarded to the ad hoc credentials review committee for a recommended action to the Privileging Authority. If the Privileging Authority's decision is to take a clinical adverse action, such action is final and will be reported to the NPDB (for privileged providers), state(s) of licensure, and other applicable certifying or regulatory agencies.

7. Any previous permission to engage in off-duty employment involving patient care is hereby withdrawn until completion of all due process procedures. Notification of this summary suspension will also be given to any other military and civilian medical treatment facilities where you maintain [privileges or practice]. [If the provider is a contractor substitute the last sentence with the following: It is your responsibility to notify other medical facilities where you hold clinical privileges that your privileges at this facility are in summary suspension].

8. [If the provider is a federal civilian, include the statement: A copy of this letter will be forwarded to the civilian personnel office. If the provider is a contractor, include the statement: A copy of this letter will be forwarded to the appropriate contracting official].

9. If you have any questions please contact (name of medical services professional) at (telephone number) and (email).

(signature of privileging authority)

Copy to:
MSP
BUMED-N01L
[others as appropriate]

Subj: NOTICE OF SUMMARY SUSPENSION

I acknowledge receipt of the Notice of Summary Suspension and the change of duty during the period of summary suspension.

I confirm the addresses and phone number listed below for all notifications to be made during this period of summary suspension. I understand it is my responsibility to change or update my contact information.

Mailing Address:

Email Address(es):

Phone Number(s):

_____ _____

Signature of Provider Date

(If provider refuses to sign, a witness will write the provider's name, date and "Provider given Notice Letter and Refused to Sign." The witness will also write "Witnessed by" and his or her name)

SAMPLE NOTICE TO PROVIDER TO SUBMIT A STATEMENT IN RESPONSE TO QUALTIY ASSURANCE INVESTIGATION

From: Privileging Authority
To: Provider

Subj: NOTICE OF RIGHT TO SUBMIT A STATEMENT IN RESPONSE TO QUALITY ASSURANCE INVESTIGATION

Ref: (a) BUMEDINST 6010.31A
(b) 10 U.S.C. §1102

Encl: (1) Redacted copy of QAI Report

1. The quality assurance investigation (QAI) into your clinical [privileges or practice] has been completed. In accordance with reference (a), a redacted copy of the QAI report without enclosures is forwarded to you in enclosure (1) for your review and right to submit a statement in response. Your statement will be reviewed and considered by an appointed ad hoc credentials committee.

2. You are advised that the QAI report is a confidential medical quality assurance document which is privileged per reference (b). You are responsible for ensuring this report is safeguarded and maintained in accordance with Federal law. You are not to disclose the contents of this report unless permitted by law. You may, however, share the report with your legal counsel understanding that the restrictions on other disclosures of the report remain in effect. You are further advised that an unauthorized release of the report may result in potential penalties. Specifically, reference (b) provides that "Any person who willfully discloses a medical quality assurance record other than provided in this section knowing that such record is a medical quality assurance record, shall be fined not more than $3000 in the case of a first offense and not more than $20,000 in the case of a subsequent offense." You are required to properly destroy this report when the clinical adverse action proceedings are completed through burning or shredding. In the alternative, you may return the report to the Privileging Authority.

3. The deadline to submit a written statement in response to the QAI is 15 calendar days from your receipt of this notice. If a statement is not received within the allotted time and you did not request an extension of time from the Privileging Authority, then the right to submit a statement is waived.

4. If you have any questions, please contact me at (telephone number) and (email).

(signature of MSP or other Privileging Authority designee)
By direction

Subj: NOTICE OF RIGHT TO SUBMIT A STATEMENT IN RESPONSE TO QUALITY ASSURANCE INVESTIGATION (QAI)

I acknowledge receipt of the Notice to Submit a Statement in Response to Quality Assurance Investigation.

_____ _____

Signature of Provider Date

(If provider refuses to sign, a witness will write the provider's name, date and "Provider given Notice Letter and Refused to Sign." The witness will also write "Witnessed by" and his or her name)

SAMPLE AD HOC CREDENTIALS COMMITTEE RECOMMENDATION

From: Chair, Ad Hoc Credentials Review Committee
To: Privileging Authority

Subj: AD HOC CREDENTIALS Review COMMITTEE RECOMMENDATION ICO [NAME OF PROVIDER]

Ref: (a) BUMEDINST 6010.31A
(b) Ad Hoc Committee Appointing Letter of [Date]

Encl: (1) Quality Assurance Investigation
(2) (Provider) written statement of [Date]

1. As required by references (a) and (b), a meeting of an ad hoc credentials review committee meeting was held on [Date] to review enclosures (1) and (2), report of Quality Assurance Investigation by [Rank, Name, Corps of Investigating Officer] and the provider's statement (if statement was provided).

2. The participating committee members were as follows: [list the Rank, Name, Corps of all the members]. [Rank, Name, Corps of member] is a clinical peer of [Name of Provider under review].

3. Based on our review, the findings are as follows: (list each allegation separately, as stated in the Quality Assurance Investigation, and then indicate if it is Substantiated or Unsubstantiated. Provide analysis and or cite to specific information to support decision).

4. The committee recommends (select one):

a. Reinstatement of Clinical [Privileges or Practice].

b. Reinstatement of Clinical [Privileges or Practice] with Monitoring and Evaluation (M&E) or Focused Professional Practice Evaluation with M&E plan.

c. Restriction of Clinical [Privileges or Practice] (identify which privileges or practice are restricted and duration.).

d. Reduction in Clinical [Privileges or Practice] (identify which privileges or practice is reduced).

e. Revocation of Clinical [Privileges or Practice]

Subj: AD HOC CREDENTIALS COMMITTEE RECOMMENDATION ICO [NAME OF PROVIDER]

f. Denial of Clinical Privileges (only applicable to privileged providers and identify which privileges are affected).

(signature of committee chair)

Date Received by Privileging Authority: _____.

SAMPLE NOTICE OF PROPOSED DECISION

From: Privileging Authority
To: Provider

Subj: NOTICE OF PROPOSED [RESTRICTION, REDUCTION, REVOCATION OR DENIAL] OF CLINICAL [PRIVILEGES OR PRACTICE]

Ref: (a) BUMEDINST 6010.31A

Encl: (1) Ad Hoc Credentials Committee Recommendation of [Date]
(2) Redacted Quality Assurance Investigation
(3) Provider Statement (if submitted)

1. Per reference (a), I have reviewed the Quality Assurance Investigation Report, your statement, and the ad hoc credentials committee recommendations. My proposed decision is to [restrict, reduce, revoke, or deny] your clinical [privileges or practice]. This action is being taken in response to the following substantiated allegations:

a.

b.

c.

2. You are advised that you have a right to request a formal peer review hearing panel to review this proposed action and to be provided the documents in enclosures (1) through (3). To invoke the right to a hearing, you must submit a written request to me within 30 calendar days from the date you receive this notification. Failure to make a written request within this time period, or failure to appear for the scheduled hearing, will result in a waiver of your right to a hearing and waiver of the right to appeal this adverse clinical action to Chief, Bureau of Medicine and Surgery. In addition, if no written hearing request is received within the allotted time, my proposed decision will become final and this adverse action will be forwarded to Chief, Bureau of Medicine and Surgery for reporting determinations to the National Practitioner Data Bank (NPDB)(privileged providers only), states of licensure, and appropriate professional organizations.

3. During this time while due process procedures are ongoing and until a final decision on your privileges is reached, your clinical [privileges or practice] will remain in summary suspension.

Subj: NOTICE OF PROPOSED [RESTRICTION, REDUCTION, REVOCATION OR DENIAL] OF CLINICAL [PRIVILEGES OR PRACTICE]

4. If you separate, retire or are discharged, or end affiliation with the Military Health System during the clinical adverse action proceedings, the proceedings will continue to completion and any adverse decision may be reported to the NPDB (for privileged providers), states of licensure, and appropriate professional organizations. You may request the continuation of your participation and due process rights after your separation, retirement, discharge, or end of employment. If you desire continuation, you must submit a request in writing to me within 5 calendar days following your knowledge of the change in your affiliation status with the Military Health system.

5. If you have any questions please contact (name of medical services professional) at (telephone number) and (email).

(signature of privileging authority)

Copy to:
MSP
BUMED-N01L
[others as appropriate]

I acknowledge receipt of the Notification of Proposed (restriction, reduction, revocation, denial) of Clinical (Privileges or Practice)

_____ _____
Signature of Provider Date

(If provider refuses to sign, a witness will write the provider's name, date and "Provider given Notice Letter and Refused to Sign." The witness will also write "Witnessed by" and his or her name)

SAMPLE NOTICE OF FINAL DECISION (REINSTATEMENT)

From: Privileging Authority
To: Provider

Subj: NOTICE OF REINSTATEMENT OF CLINICAL [PRIVILEGES OR PRACTICE]

Ref: (a) BUMEDINST 6010.31A
(b) Quality Assurance Investigation of [date]
(c) Credentials Committee Recommendation of [date]

1. Per reference (a), I have reviewed references (b) and (c), the findings and recommendations of the quality assurance investigating officer and the ad hoc credentials committee. I concur with the recommendation to (reinstate/reinstate with monitoring and evaluation or focused professional practice evaluation) your clinical [privileges or practice] effective immediately.

2. [If any allegations were substantiated, add the following statement: The following findings were substantiated during these proceedings:

[List the substantiated allegations]

[If the individual has separated from or ended affiliation with the MHS, add the following statement: These findings will be included in your close out or detaching clinical evaluation and relied upon in responding to future inquires for verification of your credentials.]

3. A summary suspension of clinical privileges that exceeds 30 calendar days must be reported to the National Practitioner Data Bank (NPDB) and state(s) of licensure. If a summary suspension was reported in this case, a revision to action report will be made to the NPDB to reflect the reinstatement of your clinical privileges.

4. [If monitoring and evaluation or placement on a focused professional practice evaluation was a condition of reinstatement include the following: Details concerning the scope and duration of monitoring and evaluation or a focused professional practice evaluation will be provided by separate correspondence.]

Subj: NOTICE OF REINSTATEMENT OF CLINICAL PRIVILEGES

5. If you have any questions please contact (name of medical services professional) at (telephone number) and (email).

(signature of privileging authority)

Copy to:
MSP
Civilian Personnel [if applicable]
Contracting Official [if applicable]
BUMED-N01L
[others as appropriate]

I acknowledge receipt of the Notice of Reinstatement of Clinical Privileges.

_____ _____
Signature of Provider Date

(If provider refuses to sign, a witness will write the provider's name, date and "Provider given Notice Letter and Refused to Sign." The witness will also write "Witnessed by" and his or her name)

SAMPLE NOTICE OF FINAL DECISION (NO HEARING)

From: Privileging Authority
To: Provider

Subj: NOTICE OF FINAL DECISION IN CLINICAL ADVERSE ACTION

Ref: (a) Proposed Decision of [date]
(b) BUMEDINST 6010.31A

1. I have not received a written request for a Peer Review Hearing Panel within the 30 calendar days of your receipt of reference (a), my proposed [restriction, reduction, revocation, denial] your clinical [privileges or practice]. As you have elected not to proceed with a hearing on this matter, and consistent with the procedures in reference (b), you have waived both your right to a hearing and to appeal the proposed adverse action.

2. This notice is to communicate my final action on your clinical privileges. You are hereby notified that my final decision is to [restrict, reduce, revoke, deny] your clinical [privileges or practice]. This action is being taken in response to the following substantiated findings:

a. List each allegation as stated in the proposed decision letter

b.

3. Per reference (b), this action is reportable to the National Practitioner Data Bank (for privileged providers), states of licensure, and other professional regulatory entities as appropriate. This action will be forwarded to Chief, Bureau of Medicine and Surgery for review of your case and reporting.

(signature of privileging authority)

Copy to:
MSP
Civilian Personnel [if applicable]
Contracting Official [if applicable]
BUMED-N01L
[others as appropriate]

Subj: NOTICE OF FINAL DECISION IN CLINICAL ADVERSE ACTION

I acknowledge receipt of the letter of notification of Final Decision in Clinical Adverse Action.

_____ _____
Provider Signature Date

(If provider refuses to sign, a witness will write the provider's name, date and "Provider given Notice Letter and Refused to Sign." The witness will also write "Witnessed by" and his or her name)

SAMPLE NOTICE OF PEER REVIEW HEARING PANEL

From: Privileging Authority
To: Provider

Subj: NOTICE OF PEER REVIEW HEARING PANEL

Ref: (a) Provider Request for Hearing
(b) BUMEDINST 6010.31A
(c) Notice of Proposed Action of [date]

Encl: (1) Peer Review Hearing Panel Witness List
(2) [Documents to be considered by the Hearing Panel

1. In response to your request in reference (a), and per reference (b), you are notified that a peer review hearing panel will meet to review allegations that may adversely affect your clinical [privileges or practice]. The following allegations will be reviewed (list the allegations as stated in the Notice of Proposed Adverse Action):

a.

b.

c.

2. The date of the hearing must be at least 30 calendar days following the receipt of this notice. The peer review hearing will be held on (date and time) at (location).

3. At the hearing, you have the right to attend, to present evidence, call witnesses on your behalf and to cross-examine witnesses called by the peer review hearing panel. While it is your responsibility to arrange for the presence of any witnesses you desire to participate in the hearing, you may request assistance in obtaining the appearance of any witness no later than 15 calendar days before the scheduled hearing. In your request, you must provide a synopsis of the witness' expected testimony with an explanation why a written statement or availability by telephone is not an adequate substitute for the witness' personal appearance.

4. You have the right to consult with and be represented by legal counsel at your own expense or to have another representative of your choosing present at the peer review hearing. Your legal counsel or other representative may actively participate in the hearing, address the peer review hearing panel, and question witnesses. (If the provider is military, add the following: You may be able to receive representation from Navy uniformed counsel consistent with Navy Judge Advocate General instructions.

Subj: NOTICE OF PEER REVIEW HEARING PANEL

5. The witnesses expected to be called to testify at the hearing and their contact information are listed in enclosure (1). The documents attached in enclosure (2) will be presented at the peer review hearing.

6. You are required to disclose the names and contact information for all witnesses testifying on your behalf and copies of all documents you intend to present at the hearing no later than 15 calendar days before the scheduled hearing.

7. You may request, in writing, a delay of the hearing for good cause; however, absent compelling circumstances (i.e., severe illness or death of a family member) delays will not be granted if the request is made less than 5 calendar days prior to the scheduled hearing. If you fail to appear at the scheduled hearing, the hearing may proceed or the Privileging Authority may consider the hearing waived and act on your privileges as stated in the written notice of proposed adverse action, reference (c).

(signature of privileging authority)

Copy to:
MSP
BUMED-N01L

I acknowledge receipt of the Notice of Peer Review Hearing Panel.

_____ _____
Signature of Provider Date

(If provider refuses to sign, a witness will write the provider's name, date and "Provider given Notice Letter and Refused to Sign." The witness will also write "Witnessed by" and his or her name)

SAMPLE APPOINTMENT OF PEER REVIEW HEARING PANEL MEMBERS

From: Privileging Authority
To: (Rank, Name, Corps of assigned Chairperson)

Subj: PEER REVIEW HEARING PANEL CONVENING ORDER

Ref: (a) BUMEDINST 6010.31A
(b) 10 U.S.C. §1102

Encl: (1) Notice of Peer Review Hearing

1. Per reference (a), you are hereby appointed as Chairperson of a Peer Review Hearing Panel to review the case of [Name of Provider]. Other individuals assigned to the Panel are:

a. Member:

b. Member:

c. Legal Advisor to Panel (non-voting):

d. Privileging Authority Representative (non-voting):

The Peer Review Hearing Panel consists of a minimum of three [privileged or non-privileged] providers, a majority of whom are peers to the healthcare provider under review. A clinical peer is one who has similar [privileges or practice], clinical specialty, and level of training. The Panel must be fair and impartial. The following members meet these criteria: [list name and specialty of clinical peers].

2. The Peer Review Hearing Panel is to review the allegations as stated in enclosure (1) and determine, based on the evidence presented, whether the allegations are substantiated or unsubstantiated and include rationale for its findings. Reference (a) provides procedural guidance on conducting the Peer Review Hearing.

3. The Peer Review Hearing Panel will make one of the following action recommendations:

a. Reinstatement of Clinical Privileges or Practice.

b. Reinstatement of Clinical Privileges or Practice with Monitoring and Evaluation (M&E) or Focused Professional Practice Evaluation (FPPE) with M&E plan. Privileges or practice reinstated with a documented plan of M&E must include clear expectations and measures of success that will be routinely reviewed throughout the period of M&E.

Subj: PEER REVIEW HEARING PANEL CONVENING ORDER

c. Restriction of Clinical Privileges or Practice (identify which privileges or areas of practice are affected).

d. Reduction in Clinical Privileges or Practice (identify which privileges or areas of practice are affected).

e. Revocation of Clinical Privileges or Practice.

f. Denial of Clinical Privileges (only applicable to privileged providers and identify which privileges are affected).

4. The Peer Review Hearing Panel will meet [choose as applicable: via teleconference or in person at [location] on [date]. The Peer Review Hearing Panel will issue a written report, with all exhibits attached, and a verbatim transcript of the hearing within 30 calendar days of hearing completion.

5. The Peer Review Hearing and all generated documentation are medical quality assurance documents within the meaning of reference (b) and disclosure of its contents is prohibited except as permitted by law.

6. If you have any questions please contact (name of medical services professional) at (telephone number) and (e-mail).

(signature of privileging authority)

Copy to:
Member [Name]
Member [Name]
Legal Advisor [Name]
Privileging Authority Representative [Name]
Provider [Name]
MSP

SAMPLE PEER REVIEW HEARING PANEL REPORT

From: Chair, Peer Review Hearing Panel
To: Privileging Authority

Subj: PEER REVIEW HEARING PANEL REPORT

Ref: (a) BUMEDINST 6010.31A
(b) Convening Order of [Date]

Encl: (1) Hearing Exhibits
(2) Verbatim Transcript

1. As required by references (a) and (b), a Peer Review Hearing Panel convened on [date] to make findings and recommendations regarding allegations which may adversely affect the clinical [privileges or practice] of [provider's name]. [Optional: the report can provide a preliminary statement if necessary to inform the privileging authority of any difficulties encountered during the hearing].

2. The hearing exhibits and verbatim transcript is provided in enclosures (1) and (2). After hearing from witnesses and reviewing exhibits, we find the following allegations are substantiated or unsubstantiated as follows:

a. **Allegation:** [list each allegation separately as stated in the Notice of Peer Review Hearing Panel letter].

(1) **Findings:** [state if the allegation is Substantiated or Unsubstantiated). Indicate if the finding was by unanimous or majority vote].

(2) **Analysis:** *Provide reasoning for findings with reference to specific information, testimony or exhibits relied upon in the Panel's decision.*

b. **Allegation:**

(1) **Findings:**

(2) **Analysis:**

3. Based on the aforementioned findings, the peer review hearing panel by [unanimous or majority] vote recommends (pick one):

a. Reinstatement of Clinical Privileges or Practice.

Subj: PEER REVIEW HEARING PANEL REPORT

b. Reinstatement of Clinical Privileges or Practice with Monitoring and Evaluation (M&E) or Focused Professional Practice Evaluation (FPPE) with M&E plan. Privileges or practice reinstated with a documented plan of M&E must include clear expectations and measures of success that will be routinely reviewed throughout the period of M&E.

c. Restriction of Clinical Privileges or Practice (identify which privileges or areas of practice are affected).

d. Reduction in Clinical Privileges or Practice (identify which privileges or areas of practice are affected).

e. Revocation of Clinical Privileges or Practice.

f. Denial of Clinical Privileges (only applicable to privileged providers and identify which privileges are affected).

Provide an analysis or explanation of what factors or information were relied upon in making this recommendation.

[If decision is not unanimous, indicate whether a minority opinion is submitted].

_____
Rank, Name, Corps, USN
Chair
Concur

_____
Rank, Name, Corps, USN
Member
Concur

_____
Rank, Name, Corps, USN
Member
Concur

Copy to:
Provider
MSP

SAMPLE NOTICE TO PROVIDER TO COMMENT ON
PEER REVIEW HEARING PANEL REPORT

From: Privileging Authority
To: Provider

Subj: NOTICE OF RIGHT TO COMMENT ON PEER REVIEW HEARING PANEL REPORT

Ref: (a) BUMEDINST 6010.31A
(b) 10 U.S.C. §1102

Encl: (1) Peer Review Hearing Panel Report of [Date]
(2) Peer Review Hearing Panel Exhibits
(3) Peer Review Hearing Transcript

1. A Peer Review Hearing Panel was convened and met on [Date(s)] to review the relevant evidence in your case, make findings on stated allegations, and issue a recommendation on your clinical [privileges or practice]. In accordance with reference (a), a copy of the Peer Review Hearing Panel record in enclosures (1) through (3) are forwarded to you for your review and right to submit a written statement of exceptions, corrections, or other comments to the Privileging Authority prior to a final decision being issued in this case.

2. You are advised that the documents provided in this notice are confidential medical quality assurance documents which are privileged per reference (b). You are responsible for ensuring these documents are safeguarded and maintained in accordance with federal law. You are not to disclose the contents of these documents unless permitted by law. You may, however, share them with your legal counsel understanding that the restrictions on other disclosures remain in effect. You are further advised that an unauthorized release of these documents may result in potential penalties. Specifically, reference (b) provides that "Any person who willfully discloses a medical quality assurance record other than provided in this section knowing that such record is a medical quality assurance record, shall be fined not more than $3000 in the case of a first offense and not more than $20,000 in the case of a subsequent offense." You are required to properly destroy these documents when the clinical adverse action proceedings are completed through burning or shredding. In the alternative, you may return the documents to the Privileging Authority.

3. The deadline to submit a written statement is 10 calendar days from your receipt of this notice. If a statement is not received within the allotted time and you did not request an extension of time from the Privileging Authority, then the right to submit a statement is waived.

Subj: NOTICE OF RIGHT TO COMMENT ON PEER REVIEW HEARING PANEL REPORT

4. If you have any questions, please contact me at (telephone number) and (email).

(signature of MSP or other privileging authority designee)
By direction

I acknowledge receipt of the Notice of Right to Comment on Peer Review Hearing Panel Report.

_____
Signature of Provider Date

(If provider refuses to sign, a witness will write the provider's name, date and "Provider given Notice Letter and Refused to Sign." The witness will also write "Witnessed by" and his or her name)

SAMPLE NOTICE OF FINAL DECISION (WITH HEARING)

From: Privileging Authority
To: Provider

Subj: NOTICE OF FINAL DECISION IN CLINICAL ADVERSE ACTION

Ref: (a) BUMEDINST 6010.31A
(b) Peer Review Hearing Panel Record
(c) Provider Statement (if submitted)

1. Per reference (a), a Peer Review Hearing Panel was convened to review the relevant evidence in your case, to make findings on the allegations, and to provide a recommendation to me on your clinical [privileges or practice]. The Peer Review Hearing was held on [Date] and the Hearing Panel submitted a report on [Date]. A copy of Peer Review Hearing Panel's report and transcript of the hearing, reference (b), were provided to you. You were afforded 10 calendar days to submit comments on the report. I have received your comments, reference (c) and have considered them in my final decision in your case. [Note: if no comments are submitted use the following: You have not submitted any comments within the allotted time or requested an extension of time to provide comments.] I have carefully and fully reviewed the Peer Review Hearing Panel record in this case.

2. You are hereby notified that my final decision is to [reinstate, reinstate with monitoring and evaluation or focused professional practice evaluation, restrict, reduce, revoke, deny] your clinical [privileges or practice]. This action is being taken in response to the following substantiated findings:

a. List each substantiated allegation, as applicable, that was alleged in the Notice of Peer Review Hearing Panel.

b.

The decision on you clinical [privileges or practice] is effective immediately.

3. [Privileging Authority comments on how the findings affect the provider's ability to practice clinically]

[If the Privileging Authority's decision differs from the Peer Review Hearing Panel's findings or recommendations, they must provide the rationale for deviating from the Panel and cite to the evidence in the Peer Review record that was relied upon in reaching the decision]

Subj: NOTICE OF FINAL DECISION IN CLINICAL ADVERSE ACTION

4. Per reference (a), this action is reportable to the National Practitioner Data Bank (for privileged providers), states of licensure, and other professional regulatory entities as appropriate.

5. You are advised that you have a right to submit a written appeal of this decision to me within 10 calendar days from receipt of this letter. The time may be extended by me for good cause. The grounds for your appeal must be stated. I will issue a written decision on your appeal. If your appeal is denied (partial or complete,) it will be forwarded to Chief, Bureau of Medicine and Surgery for review and final decision on the appeal. My decision will remain in effect during the appeal.

(signature of privileging authority)

Copy to:
MSP
Civilian Personnel [if applicable]
Contracting Official [if applicable]
BUMED-N01L
[others as appropriate]

I acknowledge receipt of the letter of notification of Final Decision in Clinical Adverse Action.

_____ _____
Provider Signature Date

(If provider refuses to sign, a witness will write the provider's name, date and "Provider given Notice Letter and Refused to Sign." The witness will also write "Witnessed by" and his or her name)

SAMPLE FORWARDING ENDORSEMENT OF
NON-APPEAL CLINICAL ADVERSE ACTION

TRANSMITTED ELECTRONICALLY

From: Privileging Authority
To: Chief, Bureau of Medicine and Surgery

Subj: NON-APPEAL OF CLINICAL ADVERSE ACTION ICO [NAME OF PROVIDER]

Ref: (a) BUMEDINST 6010.31A

Encl: (1) Peer Review Record

1. Per reference (a), enclosure (1) is forwarded in support of my final decision to [restrict, reduce, revoke, deny] [Provider name]'s (specific type) clinical [privileges or practice].

2. A quality assurance investigation (QAI) [substantiated or unsubstantiated] allegation(s) of [incompetence, misconduct or other professional conduct that adversely affects or could adversely affect the welfare of a patient or delivery of health care].

3. The QAI was submitted to the ad hoc credentials review committee to review the findings and recommendations. [Provider name] [did or did not] submit a statement for consideration by the ad hoc credentials review committee. The ad hoc committee consisted of three providers, one of whom was a clinical peer of [Provider name].

4. The ad hoc credentials review committee [concurred or non-concurred] that the aforementioned allegation(s) were [substantiated or unsubstantiated] and [unanimously or by majority] vote recommended that [provider name]'s clinical [privileges or practice] be [reinstated, restricted, reduced, revoked, denied].

5. [Provider name] was notified of my proposed decision to [restrict, reduce, revoke, deny] their clinical [privileges or practice] and was given 30 days to make a written request for a Peer Review Hearing Panel.

6. [Provider name] [choose one: submitted a response waiving their right to a Peer Review Hearing Panel; failed to request a hearing in the time permitted; submitted a request for a Peer Review Hearing Panel and the hearing was held on [date]. The hearing panel found the allegations (substantiated or unsubstantiated) and recommended (reinstatement, restriction, reduction, revocation or denial of clinical privileges or practice)].

7. A final decision was issued on [date], [restricting, reducing, revoking, denying] [provider name's] clinical [privileges or practice]. The rationale for my decision is set forth in the letter.

Subj: NON-APPEAL OF CLINICAL ADVERSE ACTION ICO [NAME OF PROVIDER]

[Provider name] acknowledged receipt of the final decision on [Date]. [If hearing held include the following: (Provider name) did not submit an appeal of this decision].

8. This action meets criteria for reporting; therefore, I recommend that [provider name] be reported to the National Practitioner Data Bank (if privileged), states of licensure, and other professional regulatory entities as appropriate.

9. If you have any questions please contact (name and title) by telephone at (number) or by e-mail at (email address).

(privileging authority signature)

Copy to:
MSP
Provider

DOCUMENT CHECKLIST FOR COMPLETED CLINICAL ADVERSE ACTION CASES

Provider Name:

Privileging Authority:

Indicate with an X documents included in the case. If document is not relevant to the case indicate it is not applicable with NA

____ Notice of Summary Suspension

____ Provider Acknowledgement

____ Notification of Summary Suspension to other entities, as appropriate

____ DHA MTFs

__ Civilian Medical Facilities (off-duty employer)

__ Provider Request for Continuation of Due Process (if affiliation with DON ends)

_____Quality Assurance Investigation (QAI) with enclosures 1 - ____

_____ Notice to Provider of Right to Submit a Statement in Response to the QAI.

_____ Provider Acknowledgement

_____ Provider Statement to Medical Executive or Credentials Review Committee (if submitted)

_____ Ad Hoc Credentials Review Committee Recommendation

_____ Date of Privileging Authority Receipt

_____ Initial Legal Sufficiency Review

_____ Notice of Proposed Decision

___ Provider Acknowledgment

_____ Notice of Final Decision (Reinstatement)

___ Provider Acknowledgment

_____ Notice of Final Decision (no hearing)

___ Provider Acknowledgment

___ Provider Request for (or waiver of) a Peer Review Hearing Panel

_____ Notice of a Peer Review Hearing Panel

___ Provider Acknowledgment

_____ Peer Review Hearing Panel Convening Order

_____ Peer Review Hearing Panel Report

_____ Peer Review Hearing Exhibits

_____ Peer Review Hearing Transcript

_____ Notice to Provider of Right to Comment on Peer Review Hearing Panel Report

___ Provider Acknowledgment

___ Provider Statement on Peer Review Hearing Panel Report

_____ Final Legal Sufficiency Review (if hearing elected)

_____ Notice of Final Decision (with hearing)

___ Provider Acknowledgment

_____ Provider Appeal of Final Decision

_____ Privileging Authority Decision on Appeal

___ Provider Acknowledgment

_____ Privileging Authority Forwarding Memorandum of Non-Appeal Clinical Adverse Action

_____ Privileging Authority Endorsement of Provider Appeal of Clinical Adverse Action

_____ Other documentation of communications between the Provider and the Privileging Authority (Provider requests for continuation, document disclosure, attendance of witnesses, etc.)