



**Title:** Peer Review Policy

**JCAHO Standard LD.03.02.01, LD.04.01.07, HR.01.06.01, HR.02.04.03: EP5, PI.03.01.01**

**Effective Date:** June 2006

**Review/Revision Date:** March 2013

**Purpose:** To ensure the organized medical staff has a consistent, equitable, timely peer review system that monitors, tracks and trends clinical outcomes, and provides relevant information for determining the competence of licensed practitioners. The peer review process is designed to be fair for practitioners, ensure patient safety, promote performance improvement, and be defensible, balanced, useful and ongoing. The information gathered contributes to decisions related to the granting of clinical privileges. Information related to peer review is protected under California Evidence Code Section 1157.

**Definitions:**

1. **Peer Review:** is the process established by the medical staff of Online Radiology Medical Group to evaluate the performance of practitioners and identify opportunities to improve care.

Peer review is conducted using multiple sources of information, including: a) the review of individual cases, b) the review of aggregate data for compliance with general rules of the medical staff, and, c) clinical standards and use of data in comparison with established norms.

The practitioner's evaluation is based on generally recognized standards of care. Through this process, practitioners receive feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional, technical, and interpersonal skills in providing patient care.

2. **Peer:** A peer is an individual practicing in the same profession and who has expertise in the appropriate subject matter. Within the ORMG environment, a peer is defined as a practitioner who practices medicine specializing in radiology.
3. **Peer Review Body:** The initial peer review body designated by the Medical Executive Committee is the Quality Assessment/Performance Improvement Committee.
4. **Focused Review:** A review of a practitioner's cases when it is identified that there may be a significant issue related to patient care or safety (see focused review policy).
5. **Confidentiality:** The entire peer review process is confidential and is protected from discovery, as provided in the ORMG Medical Staff Bylaws, and by state and federal regulations.
6. **"The Designee":** The person appointed by the ORMG medical director to administer this policy.



**Policy:**

**A. MEDICAL STAFF RESPONSIBILITY**

Members of the ORMG medical staff will be actively involved in activities to measure, assess and improve performance on an organization-wide basis. The medical staff will adhere to a fair, consistent, timely, balanced, useful and ongoing objective peer review process as described in this policy and procedure. The ORMG peer review process assesses and evaluates the quality of patient care and services based on established standards of care. The monitoring of the quality and appropriateness of patient care and safety is an ongoing, continuous process. Variations from these standards are referred for peer review. Practitioner reviewers are to be ORMG practitioners who are members of the Quality Assessment/Performance Improvement Committee.

**B. REQUIREMENTS**

Peer review is required where there are variations from established and recognized standards of care, including, but not limited to, such variations based on:

1. Medical staff approved indicators
2. Occurrence reporting that describes an unusual circumstance needing intensive review
3. Sentinel events
4. Complaints from patients, colleagues or staff regarding quality of care or services
5. Requests from outside agencies, i.e., contracted hospitals or mobile diagnostic units
6. Performance outcomes
7. Any referral deemed appropriate for peer review.

**C. TIMELINESS**

Peer review is to be conducted in a timely manner. With the exception of sentinel events, which are reviewed and reported as soon as is reasonable after the event, reviewable circumstances will be referred for peer review as soon as is reasonably possible after notification of a discrepancy or issue, but not later than the next scheduled Quality Assessment/Performance Improvement Committee meeting.

**D. PROCESS**

**1. Routine Peer Review**

ORMG will perform routine peer review for both onsite physicians and physicians providing services via teleradiology. ORMG will review up to 5% of total monthly interpretations at each facility where ORMG provides onsite radiology services. The exams to be reviewed will be comprised of all modalities rendered at the facilities. Exam review selection will be based upon each physician's activity level at the facility. The onsite physician will have a higher proportion of exams reviewed than will remote teleradiology physicians. Random cases selected, that are assigned a level of 2b or higher, will be referred to the ORMG medical director for review. After review, if the findings are upheld, the medical staff coordinator will assign the cases on the approved peer review form to



the committee members, along with supporting documentation, for review prior to the Quality Assessment/Performance Improvement Committee meeting.

## 2. Discrepancy Review

The designee will receive hospital/entity discrepancy reports. Discrepancy reports of an assigned a level of 3a and higher, will then be referred to the ORMG medical director or the ORMG medical staff president for initial review. After review, if the hospital/entity's findings are upheld, a letter will be sent to the hospital/entity informing them the case will be referred to the ORMG Quality Assessment/Performance Improvement Committee for further review. If the hospital/entity's findings are not upheld, a letter will be sent to the hospital/entity informing them of the findings and requesting the hospital/entity to conduct a re-review of its initial findings.

The cases identified to be reviewed by the Quality Assessment/Performance Improvement Committee will be sent back to the ORMG designee. The designee will also randomly identify cases read during the previous month to be reviewed by the committee. The designee will provide the case information to the medical staff coordinator to prepare for the meeting.

Prior to the Quality Assessment/Performance Improvement Committee meeting, the medical staff coordinator will forward the cases to the medical director of ORMG. The medical director of ORMG will review the cases and provide a list of the cases that should be assigned to each committee member, and that would be presented at the next Quality Assessment/Performance Improvement Committee meeting as "Cases for discussion/recommendation by the committee." Thereafter, the medical staff coordinator will assign cases on the approved peer review form to the committee members, along with supporting documentation, for review prior to the meeting. The peer review forms, along with the supporting documentation, will be distributed evenly among committee members. Each committee member will review the reports and scans online and will document the review findings and recommendations on the approved peer review form. The reviewed cases will be returned to the medical staff coordinator for inclusion in the meeting packet.

As determined by the medical director of ORMG, all other cases will be included at the end of the meeting packet as "Cases for review without discussion." The final grade, as assigned by the reviewer, will be used in the notification to the radiologist who originally signed the report.

## E. EXTERNAL PEER REVIEW

At times, there may be a need for an outside evaluation. External peer review should be considered in the following circumstances:

1. **Litigation:** When the potential for litigation exists and the QA/PI Committee requests it.
2. **Ambiguity:** When dealing with ambiguous or conflicting recommendations from internal reviewers or medical staff committees, or when there does not appear to be a strong consensus for a particular recommendation.
3. **Committee Request:** When the QA/PI Committee cannot make a determination and requests external peer review, or when a level 4 or higher disposition is assigned by the committee.



4. **Practitioner Request:** An individual practitioner whose case is under review may request external peer review.
5. **Governing Body Determination:** When the medical executive committee or board of directors determines that an outside evaluation will assist in making a determination on the competency of the practitioner.
6. **Miscellaneous Issues:** When the medical staff needs an expert witness for a fair hearing, for evaluation of a credential file, or for assistance in developing benchmarks for quality monitoring.

F. PEER REVIEW RATINGS

The following ratings will be utilized by the members of the QA/PI Committee so that objective determination of action occurs throughout the medical staff:

**Level 1** Concur with interpretation

**Level 2** Discrepancy in interpretation/not ordinarily expected to be made (understandable miss)

- 2a. Unlikely to be significant
- 2b. Likely to be significant

**Level 3** Discrepancy in interpretation/should be made most of time

- 3a. Unlikely to be significant
- 3b. Likely to be significant

**Level 4** Discrepancy in interpretation/should be made almost every time – misinterpretation of findings

- 4a. Unlikely to be significant
- 4b. Likely to be significant

G. REPORTING

The findings of peer review activities are reported to the ORMG medical director and to the MEC. A summary of peer review findings will be reported at least quarterly to the ORMG board of directors.

H. NOTIFICATION

The practitioner will be notified by letter of the conclusions of the peer review for any case assigned a level 2b or higher, and any actions, if recommended. For level 2b or higher, the practitioner will be requested to provide a response within 14 days of the date of the letter, explaining the circumstances surrounding the event referred for peer review. For actions recommended, the physician will have no more than three months to complete the action, unless a shorter or longer time frame is recommended by the committee on a case-by-case basis. A copy of the notification will be filed in the practitioner's credentials file.



**I. TRACKING**

Peer review conclusions will be tracked over time. Actions based on peer review conclusions are monitored for effectiveness. This data will be tracked and trended and provided to the medical staff as part of the ongoing professional performance evaluation process, and at the time of membership renewal, or upon request.

Remedial actions recommended by the committee when level 4 or higher dispositions are assigned will be tracked for completion on an ongoing basis. Data will be collected on all level 4 or 5 dispositions including, but not limited to, the number assigned by physician per year, modality type, area of body, and other indicators as needed. A report will be provided to the committee at least annually.

**Developed by:** ORMG Medical Staff

**Policy Primary:** Medical Director, Medical Staff President

**Scheduled Revision Date:** June 2014