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I. SCOPE:

This policy applies to _____ (“Hospital”) and its Medical Staff.

II. PURPOSE:

The purposes of this Policy are to describe the minimum standards for prospective and retrospective review of the appropriateness of operative and invasive procedures through effective use of evidence-based clinical criteria, to appropriately and accurately identify performance trends and patterns, and to monitor and improve the quality of care delivered to patients. For purposes of this policy, “Operative and Invasive Procedures” or, individually a “Procedure” shall mean Open Back Surgery, Initial Total Knee Replacement, Initial Total Hip Replacement, Hysterectomy, Bariatric Surgery and Carotid Artery procedures. Cardiac Procedures are addressed in Policy CO-5.006 Operative and Invasive Procedures Appropriateness Review - Cardiac.

III. POLICY:

Hospital shall conduct systematic, reliable reviews of Operative and Invasive Procedures as part of the peer review and quality processes set forth in the Hospital’s Medical Staff Bylaws and state statutes. The Hospital’s Peer Review Committee is responsible for providing oversight and peer review of the Operative and Invasive Procedures provided at the Hospital to confirm appropriateness of the Procedures being performed and to improve the quality of care provided at the Hospital. On a quarterly basis, the Peer Review Committee shall provide a summary of its findings to the Hospital’s Medical Executive Committee (MEC), which shall report such findings to the Hospital Governing Board.

IV. PROCEDURE:

A. Peer Review Committee

1. Committee Meetings

The Peer Review Committee shall meet regularly, in accordance with Medical Staff Bylaws, but in no event less than quarterly, to conduct the reviews as required by this Policy. On a quarterly basis, the Peer Review Committee shall report the results of its reviews and any recommendations to the MEC for further review and action as appropriate pursuant to the Medical Staff Bylaws and as outlined in Section IV.G. “Reporting.”

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2. Performance Review, Quality Monitoring, and Tracking and Trending of Data

The Peer Review Committee shall complete the required reviews as set forth in Attachment A, Operative and Invasive Monitoring Schedule. For each Procedure the Peer Review Committee evaluates under peer review, the Committee shall determine and document in the meeting minutes the final results regarding appropriateness and quality of care. On a quarterly basis, the Peer Review Committee shall report the results of its reviews and any recommendations to the MEC for further review and action as appropriate pursuant to the Medical Staff Bylaws as outlined in Section IV.G. “Reporting.”

B. Medical Record Documentation

The physician shall provide the following information, which shall be maintained in the Hospital medical record:

1. Physician documentation that validates the appropriateness of the procedure, including but not limited to: patient clinical condition, non-invasive study results, findings from diagnostic procedures.
2. Supporting diagnostic studies and reports.

C. Retrospective Appropriateness Review Utilizing Care Planning Criteria

The random sample shall be selected from Procedures from all payors that do not have a prior authorization process including but not limited to Medicare fee for service, Medicaid fee for service and Self Pay. The Hospital shall designate a Hospital Reviewer(s) to conduct retrospective reviews of a sample of Operative and Invasive Procedures to evaluate the appropriateness of the procedures identified on Attachment A, Operative and Invasive Procedure Monitoring Schedule. Hospital Reviewer shall be an individual educated by a designated INTERQUAL SIMPLUS PROCEDURES Certified Instructor. All reviews shall be completed quarterly using INTERQUAL SIMPLUS/PROCEDURES (“SIMPLUS/PROCEDURES”) criteria¹.

¹INTERQUAL SIMPLUS criteria use patient-specific characteristics and tissue analysis to retrospectively evaluate the appropriateness of surgical and invasive procedures, and INTERQUAL PROCEDURES criteria is utilized to

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[For USPI surgical facilities using Milliman, replace INTERQUAL language with “Milliman and Robertson criteria.”]

1. Sampling Methodology

The following sampling methodology shall be utilized to confirm that all physicians performing the Procedures are adequately represented in the sample:

a. Primary Sampling Methodology

[ALLSCRIPTS facilities insert the following language and delete this bracketed text:]

On a quarterly basis, a 10% random sample is created in ALLSCRIPTS for each physician performing the Procedures identified on Attachment A, which will be available to the Hospital Reviewer 15 days after the close of the quarter. Each sample shall contain a minimum of 3 and maximum of 20 Procedures per physician. For a physician with a volume of fewer than 3 Procedures during the quarter, all of the Procedures shall be included in the sample.

[Non-ALLSCRIPTS facilities insert the following language and delete this bracketed text:]

On a quarterly basis, each Hospital Reviewer shall randomly select a sample of 10% of the Procedures identified on Attachment A and performed by each physician during the prior quarter. Each sample shall contain a minimum of 3 and maximum of 20 Procedures. For a physician with a volume of fewer than 3 Procedures during the quarter, all of the Procedures shall be included in the sample.

b. Expanded Sampling Methodology

Each quarter, CAG shall identify all physicians having a Procedure volume exceeding the average of all other physicians within the

provide detail to clarify the SIMPLUS criteria.

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same Tenet market, Tenet hospital groups, or Tenet enterprise by two or more standard deviations for the same Procedure in the prior quarter. CAG shall submit to the Hospital the comparative physician level data for any physician with identified procedure volume requiring increased sample size. The Hospital Reviewer shall increase the sample for identified physicians from 10% to 20% (minimum of 3 and maximum of 30 Procedures) or more if determined by the appropriate Hospital peer review committee.

2. SIMPLUS/PROCEDURES Review Process

a. Initial Review

A Hospital Reviewer shall complete the reviews of the Procedures sampled above utilizing SIMPLUS/PROCEDURES criteria, or for supplemental reviews for which no SIMPLUS/PROCEDURES criteria exists, the evidence-based criteria approved by the Hospital's MEC.

If documentation in the medical record does not support an indication for the procedure, the Hospital Review shall be completed as "not met", and the Hospital Reviewer shall enter the result in ALLSCRIPTS. The Hospital Reviewer may then contact the physician for additional supporting documentation, but the result of initial review shall remain "not met" to enable trending by procedure and/or physician for inadequate documentation. **[For hospitals not yet using ALLSCRIPTS: replace "ALLSCRIPTS" with "a spreadsheet" and delete this bracketed text.]**

b. Secondary Review

Secondary review is required for any Procedure that did not meet appropriateness criteria upon initial review.

(1) Stage One of Secondary Review

The Hospital Reviewer shall complete stage one of the secondary review if additional documentation is obtained from the physician's office or other location that was not

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available during the initial review. If, after review of the additional documentation, the Procedure now meets criteria, the reviewer shall enter the result in ALLSCRIPTS, as “met after additional physician documentation” and there is no need for stage two of secondary review. **[For hospitals not yet using ALLSCRIPTS: replace “ALLSCRIPTS” with “a spreadsheet” and delete this bracketed text.]**

(2) Stage Two of Secondary Review

Stage two of secondary review is required if the physician does not provide additional documentation or if the additional documentation does not support an indication for the Procedure. Stage two requires review of the medical record by either the Peer Review Committee, or another Peer Physician. A “Peer Physician” must practice within the same or similar specialty but cannot be employed by, working in, or providing services to, the same group practice or have other financial interests with the physician performing the procedure. A Peer Physician may also include an independent reviewer designated by the Peer Review Committee who is not a member of the Hospital’s Medical Staff. Secondary review is complete upon final determination by peer review of whether the Procedure was appropriate. Hospital Reviewer shall enter the results of the secondary review findings in ALLSCRIPTS. **[For hospitals not yet using ALLSCRIPTS: replace “ALLSCRIPTS” with “a spreadsheet” and delete this bracketed text.]**

- c. All phases of review shall be completed within 4 months of the close of the quarter in which the Procedure was performed, including stage one (additional documentation review) and stage two (peer review) of secondary review.

D. Supplemental Appropriateness Reviews

At the direction of Hospital’s MEC, Chief Medical Officer and/or the designated quality improvement leaders at the Hospital, the Peer Review Committee may

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require review of procedures, prospective or retrospective, in addition to those required to be reviewed pursuant to this Policy. These additional procedures may include the appropriateness of operative or invasive procedures new to the Hospital, or selected high-risk, high-volume, or problem-prone procedures (procedures that are known to be high risk due to infrequent use, complexity, or those that result in a higher incidence of complications or adverse patient outcomes). All supplemental reviews, retrospective or prospective, are required to be added to Attachment A, Operative and Invasive Procedure Monitoring Schedule of this Policy.

E. External Data Reporting

If the Hospital participates in any of the following service lines, the Hospital shall participate in the identified registries and shall submit the required data on a monthly basis for purposes of evaluating performance and appropriateness of procedures compared to national benchmarks. **[Note to Hospital before finalizing this Policy: Modify the following list to match all services provided at the Hospital, and then delete bracketed comment.]**

1. The Hospital may participate in the NCDR Peripheral Vascular Intervention (PVI) registry for all Carotid Artery Stent Procedures **[Include if Hospital performs Carotid Artery Surgery Procedures]**.
2. The Hospital shall participate in all state and/or federal mandated data registries required for any of the procedures outlined in the operative and invasive policy and shall provide required data within the prescribed timeframe.

F. Auditing and Monitoring

1. External Data Reporting

The CAG shall monitor the Hospital's submission of data to required registries, including adequacy and timeliness of reporting. Each quarter, the CAG shall submit a summary report of the monitoring to the Corporate Operative and Invasive Committee. The Senior Director of Clinical Quality shall notify the Hospital CEO and DCQI of any incidents of non-compliance.

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2. Accuracy Audits of Registry Abstraction and SIMPLUS/PROCEDURES Review

- a. A qualified vendor shall perform accuracy audits on a quarterly basis at a 10% sample rate for each registry abstractor (minimum of 10 maximum of 30). The vendor shall provide the results to the Hospital DCQI and Corporate Operative and Invasive Committee.
- b. A qualified vendor shall perform accuracy audits on a quarterly basis at a 10% sample rate for each SIMPLUS/PROCEDURES reviewer (minimum of 10 maximum of 30). The vendor shall report results to the Hospital DCQI and Corporate Operative and Invasive Committee. Any Procedure that does not meet criteria in audit but met criteria under initial hospital review shall be forwarded to Peer Review Committee for determination of appropriateness under secondary review as outlined in Section IV.C.2.(b)(2).

G. Reporting

1. The Peer Review Committee shall provide a summary of its findings described in this Policy to the Hospital's MEC on a quarterly basis. At a minimum, each report shall include the following:
 - a. List of physicians requiring increased sample due to volume of procedures performed compared to peers;
 - b. Physician and/or procedure trends for the quarter for SIMPLUS/PROCEDURES reviews;
 - c. Physician and/or procedure trends for the quarter from external data registries;
 - d. Summary of actions taken to address identified issues or trends; and
 - e. Compliance with required processes outlined within this Policy.

The MEC shall address any patterns or trends identified, take appropriate action according to the peer review and quality processes set forth in the

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Hospital’s Medical Staff Bylaws and state statutes, and report its findings and actions to the Hospital Governing Board on a quarterly basis.

2. As part of the peer review and credentialing process and in furtherance of promoting quality of care, after each Peer Review Committee Meeting, but no less than quarterly, the Hospital DCQI shall complete and forward Attachment B, Notification of Procedure Determinations regarding the status of peer review referrals to the Compliance Officer for any and all applicable determinations, including refunds or other appropriate follow up. The Compliance Officer shall provide a summary of review and actions taken to the Compliance Committee and/or other appropriate committees on a quarterly basis.

H. Annual Approval

The Corporate Operative and Invasive Committee shall review the policy requirements annually and communicate any revisions to the Hospitals by October 1st. The MEC shall review the policy annually and approve the procedures identified for retrospective review and criteria for review. The MEC shall also identify and approve any supplemental reviews, if appropriate.

I. Responsible Person

The Hospital DCQI and Hospital Chief Medical Officer, if applicable, with oversight by the CEO, are responsible for full implementation of this Policy. The Hospital CEO shall coordinate with the Hospital leaders to evaluate whether appropriate peer review processes are implemented as required by this Policy. All non-compliance with the Policy shall be reported to the Compliance Officer.

J. Enforcement

All Hospital Staff and Medical Staff Members whose responsibilities are affected by this Policy are expected to be familiar with the basic procedures and responsibilities created by this Policy. Failure to comply with this Policy shall be subject to appropriate performance management and/or disciplinary action pursuant to all applicable policies and procedures, including the Medical Staff Bylaws, Rules and Regulations.

V. REFERENCES:

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VI. ATTACHMENTS:

Attachment A: Operative and Invasive Monitoring Schedule

Attachment B: Notification of Procedure Determinations