**Section 250.310 Organization**

a) For the purposes of this Section only:

1) *Adverse Decision − means a decision reducing, restricting, suspending, revoking, denying, or not renewing medical staff membership or clinical privileges*. (Section 10.4(b) of the Act)

2) A Distant-site Hospital − means an Illinois licensed hospital or a Medicare participating hospital.

3) A Distant-site Telemedicine Entity – means an entity consisting of a group of licensed physicians that:

A) Provides telemedicine services;

B) Is not a Medicare-participating hospital; and

C) Provides contracted services in a manner that enables a hospital using its services to meet all applicable Medicare conditions of participation, particularly those requirements related to the credentialing and privileging of practitioners providing telemedicine services to the patients of a hospital. A distant-site telemedicine entity would include a distant-site hospital that does not participate in the Medicare program that is providing telemedicine services to a Medicare-participating hospital.

4) *Economic Factor − means any information or reasons for decisions unrelated to quality of care or professional competency*. (Section 10.4(b) of the Act)

5) Non-simultaneously − means that, while the telemedicine physician or practitioner still provides clinical services to the patient upon a formal request from the patient's attending physician, these services may, for example, involve after-the-fact interpretation of diagnostic tests, consultations between a physician or practitioner and a person outside the State of Illinois, or second opinions provided to an Illinois-licensed physician or practitioner in order to provide an assessment of the patient's condition and do not necessarily require the telemedicine practitioner to directly assess the patient in real time or establish a provider-to-patient relationship or interaction. An example of after-the-fact interpretation of diagnostic tests would be similar to the services provided by an on-site radiologist who interprets a patient's x-ray or CT scan and then communicates the assessment to the patient's attending physician who then bases a diagnosis and treatment plan on these findings.

6) *Privilege − means permission to provide medical or other patient care services and permission to use hospital resources, including equipment, facilities and personnel that are necessary to effectively provide medical or other patient care services. This definition shall not be construed to require a hospital to acquire additional equipment, facilities, or personnel to accommodate the granting of privileges*. (Section 10.4(b) of the Act)

7) Simultaneously − means that the clinical services (for example, assessment of the patient with a clinical plan for treatment, including any medical orders needed) are provided to the patient in real time by the telemedicine physician or practitioner, similar to the actions of an on-site physician or practitioner.

8) Telemedicine − means the provision of clinical services to patients by physicians or practitioners remotely via electronic communications. The distant-site telemedicine physician or practitioner provides clinical services to the hospital patient either simultaneously, as is often the case with teleICU services, for example, or non-simultaneously, as may be the case with many teleradiology services. Telemedicine may also include provider-to-provider consultations between Illinois-licensed physicians or practitioners and physicians or practitioners licensed in the United States.

b) The medical staff shall be organized in accordance with written bylaws, rules and regulations approved by the governing board. The bylaws, rules and regulations shall specifically provide, but are not limited to:

1) establishing written procedures relating to the acceptance and processing of initial applications for medical staff membership, granting and denying of medical staff reappointment, and medical staff membership or clinical privileges disciplinary matters in accordance with subsection (e) for county hospitals as defined in Section 15-1(c) of the Illinois Public Aid Code, or subsection (f) for all other hospitals. The procedures for initial applicants at any particular hospital may differ from those for current medical staff members. However, the procedures at any particular hospital shall be applied equally to each practitioner eligible for medical staff membership as defined in Section 250.100. The procedures shall provide that, *prior to the granting of any medical staff privileges to an applicant, or renewing a current medical staff member's privileges,* the hospital *shall request of the Director of the Department of Financial and Professional Regulation information concerning the licensure status, proper credentials, required certificates, and any disciplinary action taken against the applicant's or medical staff member's license.* This provision shall not apply to *medical personnel who enter a hospital to obtain organs and tissues for transplant from a deceased donor in accordance with the Illinois Anatomical Gift Act*. This provision shall not apply to *medical personnel who have been granted disaster privileges pursuant to the procedures and requirements established* in this Section. (Section 10.4(a) of the Act);

2) identifying divisions and departments as are warranted (as a minimum, active and consulting divisions are required);

3) identifying officers as are warranted;

4) establishing committees as are warranted to assure the responsibility for functions such as pharmacy and therapeutics, infection control, utilization review, patient care evaluation, and the maintenance of complete medical records;

5) assuring that active medical staff meetings are held regularly, and that written minutes of all meetings are kept;

6) reviewing and analyzing the clinical experience of the hospital at regular intervals − the medical records of patients to be the basis for review and analysis;

7) identifying conditions or situations that require consultation, including consultation between medical staff members in complicated cases;

8) examining tissue removed during operations by a qualified pathologist and requiring that the findings are made a part of the patient's medical record;

9) keeping completed medical records;

10) maintaining a Utilization Review Plan, which shall be in accordance with the Conditions of Participation for Hospitals;

11) establishing Medical Care Evaluation Studies;

12) establishing policies requiring a physician as first assistant to major or hazardous surgery, including written criteria to determine when an assistant is necessary;

13) assuring, through credentialing by the medical staff, that a qualified surgical assistant, whether a physician or non-physician, assists the operating surgeon in the operating room;

14) determining additional privileges that may be granted a staff member for the use of the staff member's employed allied health personnel in the hospital in accordance with policies and procedures recommended by the medical staff and approved by the governing body. The policies and procedures shall include, at least, requirements that the staff member requesting this additional privilege shall submit the following for review and approval by the medical staff and the governing body of the hospital:

A) a curriculum vitae of the identified allied health personnel, and

B) a written protocol with a description of the duties, assignments and functions, including a description of the manner of performance within the hospital by the allied health personnel in relationship with other hospital staff;

15) establishing a mechanism for assisting medical staff members in addressing physical and mental health problems;

16) implementing a procedure for preserving medical staff credentialing files in the event of the closure of the hospital;

17) establishing a procedure for granting telemedicine privileges, based upon the privileging decisions of a distant-site hospital or telemedicine entity that has a written agreement that meets Medicare requirements; and

18) establishing a procedure for granting disaster privileges.

A) When the emergency management plan has been activated and the hospital is unable to handle patients' immediate needs, it shall:

i) identify in writing the individuals responsible for granting disaster privileges;

ii) describe in writing the responsibilities of the individuals granting disaster privileges. The responsible individual is not required to grant privileges to any individual and is expected to make decisions on a case-by-case basis at his or her discretion;

iii) describe in writing a mechanism to manage individuals who receive disaster privileges;

iv) include a mechanism to allow staff to readily identify individuals who receive disaster privileges;

v) require that medical staff address the verification process as a high priority and begin the verification process of the credentials and privileges of individuals who receive disaster privileges as soon as the immediate situation is under control.

B) The individual responsible for granting disaster privileges may grant disaster privileges upon presentation of any of the following:

i) a current picture hospital ID card;

ii) a current license to practice and a valid picture ID issued by a state, federal or regulatory agency;

iii) identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or an Illinois Medical Emergency Response Team (IMERT);

iv) identification indicating that the individual has been granted authority to render patient care, treatment and services in disaster circumstances (authority having been granted by a federal, state or municipal entity); or

v) presentation by current hospital or medical staff members with personal knowledge regarding practitioner's identity.

C) *Any hospital and any employees of the hospital or others involved in granting privileges who, in good faith, grant disaster privileges, pursuant to Section 10.4 of* the *Act, to respond to an emergency shall not, as a result of their acts or omissions, be liable for civil damages for granting or denying disaster privileges except in the event of willful and wanton misconduct, as that term is defined in Section 10.2 of* the *Act.*

D) *Individuals granted privileges who provide care in an emergency situation, in good faith and without direct compensation, shall not, as a result of their acts or omissions, except for acts or omissions involving willful and wanton misconduct, as that term is defined in Section 10.2 of* the *Act, on the part of the person, be liable for civil damages.* (Section 10.4 of the Act)

c) General Acute or Critical Access Hospitals without a licensed pediatric unit or board certified or board eligible pediatrician in the hospital or on call 24 hours a day, 7 days a week that provide limited inpatient or observation services to pediatric patients (neonate (less than 28 days of age) to 14 years old):

1) Shall have a written agreement with a children’s hospital or hospital with a licensed pediatric unit. The agreement shall include provider-to-patient and/or provider-to-provider consultations that meet the telemedicine requirements provided in subsections (a)(2) through (a)(8) remotely via electronic communications, whether synchronous or asynchronous, and specify other information including communication frequency, equipment, education, transfers, case reviews, and critical criteria for emergency transfers;

2) Must have an agreement with one primary hospital, for the purposes of continuing education and consultation, but are encouraged to have agreements with multiple hospitals, in order to ensure options when a transfer is warranted but restricted from accommodation due to primary hospital census or family preference;

3) May have agreements with out-of-state hospitals who have agreements with the Department under the Regionalized Perinatal Health Care Code (77 Ill. Adm. Code 640) and designated as a trauma center by the Department in accordance with Section 3.90 of the Emergency Medical Services (EMS) Systems Act;

4) May include a fee for provider-to-patient and/or provider-to-provider consultations with the consulting hospital in the written agreement, but the fee may not be transferred to the patient;

5) Shall have until June 1, 2024 to enter into an agreement, or amend an existing agreement, as required in this subsection (c);

6) Shall consult with the children’s hospital or hospital with licensed pediatric unit prior to the patient being moved to a medical/surgical unit from either the emergency department or post-operative procedure unit. In cases where the consultation cannot occur prior to the move, the consultation must occur within one hour after the patient has been placed on the medical/surgical unit as an inpatient or in observation status. The frequency of the consultations during the pediatric patient’s stay shall be determined by the health care provider and shall continue until the patient is discharged or transferred;

7) Shall maintain a record of the consultation in the pediatric patient’s medical file;

8) Shall report pediatric services provided pursuant to the requirements of this subsection (c) to the Department quarterly as required by Section 250.1520(i); and

9) Shall not require providers who give provider-to-provider consultations to be privileged at the hospital where the patient is receiving treatment.

d) If a hospital is part of a hospital system consisting of two or more separately licensed hospitals, and the system elects to have a unified, integrated medical staff for its separately licensed member hospitals, each separately licensed hospital shall permit the medical staff members of each separately licensed hospital in the system (in other words, all medical staff members who hold specific privileges to practice at that hospital) to vote, in accordance with medical staff bylaws, whether to accept a unified, integrated medical staff structure or to maintain a separate and distinct medical staff for their respective licensed hospital.

1) If the medical staffs of the separately licensed hospitals vote to accept an integrated, unified medical staff structure, they shall meet the following conditions:

A) Adopt written bylaws, rules and requirements that describe the processes for self-governance, appointment, credentialing, privileging and oversight, as well as peer review policies and due process rights guarantees, including a process for the members of the medical staff of each separately licensed hospital to be advised of their rights to opt out of the unified and integrated medical staff structure after a majority vote by the members to maintain a separate and distinct medical staff for their hospital;

B) Take into account each member hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital; and

C) Establish and implement written policies and procedures, including meetings that shall occur at least twice per fiscal or calendar year, to ensure that the needs and concerns expressed by members of the medical staffs at each separately licensed hospital, regardless of practice or location, are given due consideration, and that the unified, integrated medical staff has mechanisms in place to ensure that issues localized to particular hospitals are considered and addressed.

2) The unified, integrated medical staff shall be organized in accordance with the Conditions of Participation for Hospitals related to medical staff.

3) Medical staffs may vote, no more than every two years, whether to remain or discontinue as an integrated, unified medical staff.

4) This subsection (d) shall not apply to hospitals that are required to have a unified, integrated medical staff under 42 CFR 413.65(d) and (e) as being a multi-campus hospital under one Medicare certification number.

e) The medical staff bylaws for county hospitals as defined in Section 15-1(c) of the Illinois Public Aid Code shall include at least the following:

1) The procedures relating to evaluating individuals for staff membership, whether the practitioners are or are not currently members of the medical staff, shall include procedures for determining qualifications and privileges; criteria for evaluating qualifications; and procedures requiring information about current health status, current license status in Illinois, and biennial review of renewed license.

2) Written procedures that allow the medical staff to rely upon the credentialing and privileging decisions of a distant-site hospital or telemedicine entity as an option for recommending the privileging of telemedicine physicians.

3) The procedure shall grant to current medical staff members at least: written notice of an adverse decision by the governing board; an explanation and reasons for an adverse decision; the right to examine and/or present copies of relevant information, if any, related to an adverse decision; an opportunity to appeal an adverse decision; and written notice of the decision resulting from the appeal. The procedures for providing written notice shall include timeframes for giving notice.

f) The medical staff bylaws for *all hospitals except county hospitals* shall include at least the following *provisions* for *granting, limiting, renewing, or denying medical staff membership and clinical staff privileges*:

1) *Minimum procedures for pre-applicants or applicants for medical staff membership, including the following:*

A) *Written procedures relating to the acceptance and processing of pre-applicants or applicants for medical staff membership.*

B) *Written procedures to be followed in determining a pre-applicant's or an applicant's qualifications for being granted medical staff membership and privileges.*

C) *Written criteria to be followed in evaluating a pre-applicant's or an applicant's qualifications.*

D) *An evaluation of a pre-applicant's or an applicant's current health status and current license status in Illinois.*

E) *A written response to each pre-applicant or applicant that explains the reason or reasons for any adverse decision (including all reasons based in whole or in part on the applicant's medical qualifications or any other basis, including economic factors).*

F) Written procedures that allow the medical staff to rely upon the credentialing and privileging decisions of a distant-site hospital or telemedicine entity as an option for recommending the privileging of telemedicine physicians.

2) *Minimum procedures with respect to medical staff and clinical privilege determinations concerning current members of the medical staff shall include the following:*

A) *A written notice of an adverse decision and* *explanation of the reasons for an adverse decision including all reasons based on the quality of medical care or any other basis, including economic factors.*

B) *A statement of the medical staff member's right to request a fair hearing on the adverse decision before a hearing panel whose membership is mutually agreed upon by the medical staff and the hospital governing board. The hearing panel shall have independent authority to recommend action to the hospital governing board. Upon the request of the medical staff member or the hospital governing board, the hearing panel shall make findings concerning the nature of each basis for any adverse decision recommended to and accepted by the hospital governing board.*

i) *Nothing in* this subsection (f)(2)(B) *limits a hospital's or medical staff's right to summarily suspend, without a prior hearing, a person's medical staff membership or clinical privileges if the continuation of practice of a medical staff member constitutes an immediate danger to the public, including patients, visitors, and hospital employees and staff.*

ii) *In the event that a hospital or the medical staff imposes a summary suspension, the Medical Executive Committee, or other comparable governance committee of the medical staff as specified in the bylaws, must meet as soon as is reasonably possible to review the suspension and to recommend whether it should be affirmed, lifted, expunged, or modified if the suspended* medical staff member *requests a review.*

iii) *A summary suspension may not be implemented unless there is actual documentation or other reliable information that an immediate danger exists. This documentation or information must be available at the time the summary suspension decision is made and when the decision is reviewed by the Medical Executive Committee.*

iv) *If the Medical Executive Committee recommends that the summary suspension should be lifted, expunged, or modified, this recommendation must be reviewed and considered by the hospital governing board, or a committee of the board, on an expedited basis.*

v) *Nothing in this* subsection (f)(2)(B) *shall affect the requirement that any requested hearing must be commenced within 15 days after the summary suspension and completed without delay unless otherwise agreed to by the parties.*

vi) *A fair hearing shall be commenced within 15 days after the suspension and completed without delay, except that, when the medical staff member's license to practice has been suspended or revoked by the* Department of Financial and Professional Regulation, *no hearing shall be necessary.* (Section 10.4(b)(2)(C)(i) of the Act)

vii) *Nothing in* this subsection (f)(2)(B) *limits a medical staff's right to permit, in the medical staff bylaws, summary suspension of membership or clinical privileges in designated administrative circumstances as specifically approved by the medical staff. This bylaw provision must specifically describe both the administrative circumstance that can result in a summary suspension and the length of the summary suspension. The opportunity for a fair hearing is required for any administrative summary suspension. Any requested hearing must be commenced* *within 15 days after the summary suspension and completed without delay. Adverse decisions other than suspension or other restrictions on the treatment or admission of patients may be imposed summarily and without a hearing under designated administrative circumstances as specifically provided for in the medical staff bylaws as approved by the medical staff.* (Section 10.4(b)(2)(C)(ii) of the Act)

viii) *If a hospital exercises its option to enter into an exclusive contract and that contract results in the total or partial termination or reduction of medical staff membership or clinical privileges of a current medical staff member, the hospital shall provide the affected medical staff member 60 days prior notice of the effect on his or her medical staff membership or privileges. An affected medical staff member desiring a hearing under* this subsection (f)(2)(B) *must request the hearing within 14 days after the date he or she is so notified. The requested hearing shall be commenced and completed (with a report and recommendation to the affected medical staff member, hospital governing board, and medical staff) within 30 days after the date of the medical staff member's request. If agreed upon by both the medical staff and the hospital governing board, the medical staff bylaws may provide for longer time periods.* (Section 10.4(b)(2)(C)(iii) of the Act)

C) A *statement of the member's right to inspect all pertinent information in the hospital's possession with respect to the decision.*

D) *A statement of the member's right to present witnesses and other evidence at the hearing on the decision.*

E) *The right to be represented by a personal attorney.*

F) *A written notice and written explanation of the decision resulting from the hearing.*

G) *A written notice of a final adverse decision by the hospital governing board.*

H) *Notice given 15 days before implementation of an adverse medical staff membership or clinical privileges decision based substantially on economic factors. This notice shall be given after the medical staff member exhausts all applicable procedures under* subsection (f)(2)(B)(viii), *and under the medical staff bylaws in order to allow sufficient time for the orderly provision of patient care.* (Section 10.4(b)(2)(D) through (G) of the Act)

3) *Nothing in* subsection (f)(2) *limits a medical staff member's right to waive, in writing, the rights provided* *in* subsection (f)(2)(A) through (H) *upon being granted* privileges to provide telemedicine services or *the written exclusive right to provide particular services at a hospital, either individually or as a member of a group. If an exclusive contract is signed by a representative of a group of physicians, a waiver contained in the contract shall apply to all members of the group unless stated otherwise in the contract.* (Section 10.4(b)(2)(H) of the Act)

4) *All peer review used for the purpose of credentialing, privileging, disciplinary action, or other recommendations affecting medical staff membership or exercise of clinical privileges, whether relying in whole or in part on internal or external reviews, shall be conducted in accordance with the medical staff bylaws and applicable rules, regulations, or policies of the medical staff. If external review is obtained, any adverse report utilized shall be in writing and shall be made part of the internal peer review process under the bylaws. The report shall also be shared with a medical staff peer review committee and the individual under review. If the medical staff peer review committee or the individual under review prepares a written response to the report of the external peer review within 30 days after receiving the report, the governing board shall consider the response prior to the implementation of any final actions by the governing board which may affect the individual's medical staff membership or clinical privileges. Any peer review that involves willful or wanton misconduct shall be subject to civil damages as provided for under Section 10.2 of* the *Act.* (Section 10.4(b)(2)(C-5) of the Act)

5) *Every adverse medical staff membership and clinical privilege decision based substantially on economic factors shall be reported to the Hospital Licensing Board before the decision takes effect. The reports shall not be disclosed in any form that reveals the identity of any hospital or physician. These reports shall be utilized to study the effects that hospital medical staff membership and clinical privilege decisions based upon economic factors have on access to care and the availability of physician services*. (Section 10.4(b)(3) of the Act)

g) If a hospital enters into agreement for telemedicine services with a distant-site hospital or distant-site entity, the governing body of the hospital whose patients are receiving the telemedicine services may choose, in lieu of the hospital performing the credentialing and privileging requirements, to rely upon the credentialing and privileging decisions made by the distant-site hospital when making recommendations on privileges for the individual distant-site physicians and practitioners providing the services. The hospital's governing body ensures, through its written agreement with the distant-site hospital, that the distant-site hospital meets the Conditions of Participation for Hospitals for credentialing and privileging of physicians and practitioners. The agreement shall be in writing and shall verify:

1) That the distant-site hospital providing the telemedicine services is an Illinois licensed hospital or a Medicare participating hospital;

2) That the individual distant-site physician or practitioner is privileged at the distant-site hospital that provides the telemedicine services and provides to the hospital a current list of the distant-site physician's privileges;

3) That the individual distant-site physician or practitioner holds a license issued or recognized by the State of Illinois; and

4) That, if the hospital conducts an internal review of the distant-site physician's or practitioner's performance, it provides the distant-site hospital with the performance information for use in the distant-site hospital's periodic appraisal of the distant-site physician or practitioner. At a minimum, this information shall include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the hospital's patients and all complaints the hospital has received about the distant-site physician or practitioner.

h) The hospital's governing body shall grant privileges to each telemedicine physician or practitioner providing services at the hospital under an agreement with a distant-site hospital or telemedicine entity before the telemedicine physician or practitioner may provide telemedicine services. The scope of the privileges granted to the telemedicine physician or practitioner shall reflect the provision of the services offered via a telecommunications system.

i) When the hospital's governing body exercises the option to grant privileges based on its medical staff recommendations, which rely upon the privileging decisions of a distant-site telemedicine hospital or entity, the governing body may, but is not required to, maintain a separate file on each telemedicine physician or practitioner. In lieu of maintaining a separate file on each telemedicine physician or practitioner, the hospital may have a file on all telemedicine physicians or practitioners providing services at the hospital under each agreement with a distant-site hospital or telemedicine entity, indicating which telemedicine services privileges the hospital has granted to each physician or practitioner on the list. The file or files may be kept in a format determined by the hospital.

j) Regardless of any other categories (divisions of the medical staff) having privileges in the hospital, the hospital shall have an active staff, which shall include physicians and may also include podiatrists and dentists, properly organized, who perform all the organizational duties pertaining to the medical staff. These duties include:

1) Maintaining the proper quality of all medical care and treatment of inpatients and outpatients in the hospital. Proper quality of medical care and treatment includes:

A) availability and use of accurate diagnostic testing for the types of patients admitted;

B) availability and use of medical, surgical, and psychiatric treatment for patients admitted;

C) availability and use of consultation, diagnostic tools and treatment modalities for the care of patients admitted, including the care needed for complications that may be expected to occur; and

D) availability and performance of auxiliary and associate staff with documented training and experience in diagnostic and treatment modalities in use by the medical staff and documented training and experience in managing complications that may be expected to occur.

2) Organizing the medical staff, including adoption of rules and regulations for its government (which require the approval of the governing body), election of its officers or recommendations to the governing body for appointment of the officers, and recommendations to the governing body upon all appointments to the staff and grants of hospital privileges.

3) Making other recommendations to the governing body regarding matters within the purview of the medical staff.

k) The medical staff may include one or more divisions in addition to the active staff, but this in no way modifies the duties and responsibilities of the active staff.

(Source: Amended at 48 Ill. Reg. 450, effective December 20, 2023; expedited correction at 48 Ill. Reg. 5807, effective December 20, 2023)