


<p><b>Name of Policy:</b> Practice location approval.</p> <p><b>Policy Number:</b> 3364-10-06</p> <p><b>Approving Officer:</b> Executive Vice President for Clinical Affairs and Dean, College of Medicine &amp; Life Sciences</p> <p><b>Responsible Agent(s):</b> Administrator for Risk Management</p> <p><b>Scope:</b> The University of Toledo and University of Toledo Physicians</p>	 <p><b>Effective date:</b> 5/1/16</p>
<input type="checkbox"/> New policy proposal	<input checked="" type="checkbox"/> Minor/technical revision of existing policy
<input type="checkbox"/> Major revision of existing policy	<input type="checkbox"/> Reaffirmation of existing policy

(A) Policy statement

The University of Toledo (“UT”) professional liability insurance program provides coverage to physicians and certain clinical associates (“Insured(s)”) of The University of Toledo Physicians, LLC (“UTP”) who practice at practice locations that have been approved by the Executive Vice President for Clinical Affairs and UT Dean, College of Medicine & Life Sciences (“Executive VP”). Practice locations owned or controlled by UT or UTP (see Appendix A) have been pre-approved, however, Practice Location Fact Sheets and Procedure Checklists do need to be submitted to Risk Management for entry into the practice location database.

(B) Purpose of policy

To provide a procedure for approving the practice locations of Insureds for coverage under the UT professional liability insurance program.

(C) Procedure

(1) Professional liability insurance underwriting

An individual’s underwriting approval for professional liability insurance coverage in the UT professional liability insurance program will not be delayed pending the practice location review process, however, all attempts will be made to identify and approve the locations as soon as practical so the insurance program will be able to keep an accurate, up to date record of the insurance coverage dates and locations.

(2) Practice location approval process at the time of initial hiring or staff appointment

(a) The Administrator for Risk Management will review the Fact Sheets and Procedure Checklists that are part of the Application for Appointment. If

any additional information is needed, the Administrator for Risk Management will obtain it directly from the Insured.

- (b) When the Fact Sheets and Procedure Checklists are deemed complete, the Administrator for Risk Management will attach an Approval Form to the set of forms for each practice location requiring approval (i.e. those locations not listed in Appendix A). This makes up the Approval Packet for each practice location.
  - (c) The Approval Packets will be sent to the following individuals, in the order listed on the Approval Form. Each individual will indicate either approval or non-approval and forward the forms on to the next individual.
    - (i) Insured's Department Chairperson; then to
    - (ii) Executive VP; then to
    - (iii) Executive Director of UTP; and then return to
    - (iv) Administrator for Risk Management.
  - (d) Approval with conditions may also be granted. The condition or restriction applying to a particular practice location will be noted in the comments of the approval section of the Approval Form by the individual setting the condition.
  - (e) The completed Approval Packet (whether approved or denied) will be returned to the Administrator for Risk Management, who will then forward a copy to the Insured, Department Chairperson, UTP Human Resources and the Central Verification Office (for Provider Enrollment).
  - (f) Risk Management will update its practice location database.
- (3) New practice location approval process after initial appointment
- (a) An Insured wishing to have a new practice location added to his/her current approved locations will fill out a Fact Sheet and Procedure Checklist for that new location.
  - (b) If the location is not listed on Appendix A as pre-approved, the Insured will complete the upper part of the Approval Form and attach it to the Fact Sheet and Procedure Checklist specific to the location. This makes up the Approval Packet for that practice location.
  - (c) The above sections (2) (c) through (2) (f) are completed.
  - (d) If the location is listed on Appendix A and does not require further approval, then the Fact Sheet and Procedure Checklist are sent directly to Risk Management.

## (4) Annual practice location audit

- (a) Each Insured will be surveyed on an annual basis with respect to their practice locations.
  - (i) On even numbered years, the Administrator for Risk Management will provide each Insured with a listing of their locations that are in the Risk Management practice location database and the Insured will update the list as appropriate.
  - (ii) On odd numbered years, the Administrator for Risk Management will provide each Insured with a copy of the Fact Sheet and Procedure Checklist for each location that is in the Risk Management practice location database and the Insured will update the information as appropriate.
- (b) During the annual audit, Insureds will be instructed to complete a new Fact Sheet and Procedure Checklist for any location where they practice but forms are lacking.
- (c) Any returned forms that contain significant changes or any form for a new location requiring approval will have an Approval Form attached by the Administrator for Risk Management and will be forwarded for approval as outlined in section (3) above.

## (5) Appeal process for non-approval or conditional approval

The Insured or Department Chairperson may appeal the non-approval or conditional approval of any location to the individual who disapproved or placed a conditional approval on the location. The Administrator for Risk Management will be advised of any change in approval status following the appeal.

## (6) Forms

The following three forms will make up a practice location approval packet ("Approval Packet") and will be completed by Insureds for each location where they are seeking to practice.

- (a) Practice Location Approval Form: This form is used for any location that requires approval and is not listed on Appendix A. It serves as the cover page that is attached to each Practice Location Fact Sheet and Procedure Checklist and documents the approval process for a particular practice location. This form will be signed off by the Insured's Department Chairperson, Executive VP and Executive Director of UTP.
- (b) Practice Location Fact Sheet: This form must be completed for every location where an Insured intends to practice. It is used to evaluate that particular location's role in supporting the teaching mission, research

mission and strategic mission of UT. This form is completed for all practice locations, even those pre-approved locations listed in Appendix A.

- (c) Practice Location Procedure Checklist: This form must be completed for every location where an Insured intends to practice. It is used to evaluate the type of practice and procedures that will be done at that particular location and helps establish the insurance risk rating for that location. The Checklist has nothing to do with credentialing or privileging at that location. This form is completed for all practice locations, even those pre-approved locations listed in Appendix A.

(7) Quarterly practice location reports

The Administrator for Risk Management will provide the Executive VP, UTP Chief Financial Officer and Director of the Central Verification Office a quarterly report of all UTP Insureds and their practice locations.

<p>Approved by:</p> <p><u>/s/ Christopher J. Cooper</u> Executive Vice President for Clinical Affairs and Dean, College of Medicine &amp; Life Sciences</p> <p><u>June 1, 2016</u> Date</p> <p><i>Review/Revision Completed by: University of Toledo Physicians President University of Toledo Physicians Executive Director Office of Legal Affairs – Health Science Campus</i></p>	<p>Policies Superseded by This Policy: None</p> <p>Initial Effective Date: 1/1/2008 Review/Revision Date: 9/1/2011 Review/Revision Date: 3/18/2014 Review/Revision Date: 10/1/15 Review/Revision Date: 5/1/16 Next review date: 5/1/19</p>
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## **Appendix A**

### **UT/UTP Practice Locations Pre-Approved by the Executive Vice President for Clinical Affairs**

- Community Care Clinic (all locations)
- Dana Cancer Center
- Fallen Timbers Primary Care (3100 Main Street, Maumee)
- Glendale Medical Center
- Glendale Medical East
- Kobacker Center
- Lourdes University Clinic (4900 N. McCord Road, Sylvania)
- Main Campus Medical Center
- ProMedica Facilities
  - ProMedica Bay Park Hospital
  - ProMedica Bixby Hospital
  - ProMedica Defiance Regional Hospital
  - ProMedica Flower Hospital
  - ProMedica Fostoria Community Hospital
  - ProMedica Health and Wellness Center
  - ProMedica Herrick Hospital
  - ProMedica Memorial Hospital
  - ProMedica Monroe Regional Hospital
  - ProMedica St. Luke's Hospital
  - ProMedica Toledo Hospital
  - ProMedica Toledo Children's Hospital
  - ProMedica Wildwood Orthopaedic and Spine Hospital
- Regency Office (1000 Regency Court, Toledo)
- Regional Center for Sleep Medicine (4041 W. Sylvania Ave., Toledo)
- Rehabilitation Hospital of Northwest Ohio (1455 W. Medical Loop, Health Science Campus)
- Rocket Pediatrics – Waterville (1089 Pray Blvd., Waterville)
- Ruppert Health Center
- Sports Medicine Program (Various school locations)
- Talmadge Primary Care (Talmadge Town Center, 4204 Sylvania Ave, Toledo)
- The University of Toledo Heart & Vascular Center (28442 E. River Road, Suite #110, Perrysburg)
- The University of Toledo Medical Center (including Medical Pavilion and Isaac Surgery Center)
- UT Pediatrics – Perrysburg (1103 Village Square Dr., Perrysburg)

**Appendix B**  
**PRACTICE LOCATION APPROVAL FORM**

- Use one Approval Form for each practice location.
- Attach fully completed forms specific to this location:
  - ✓ Practice Location Fact Sheet
  - ✓ Procedure Checklist
- Forward Approval Form & attachments to Department Chairperson.



Practitioner Name: \_\_\_\_\_ Date of Request: \_\_\_\_\_

Specialty: \_\_\_\_\_ Department: \_\_\_\_\_

Location Name: \_\_\_\_\_

Please check one:    ✓

This location request is part of my initial employment process.

-- OR --

This location is being requested as a new location to my existing approved locations.

**Approval Process**

Department Chairperson:     Approved     Not Approved

Comments: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Executive Vice President for Clinical Affairs:    Approved    Not Approved

Comments: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

UTP Executive Director:                            Approved     Not Approved

Comments: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Return Fully Signed Approval Form and Attachments to  
UTMC Administrator for Risk Management**

# Appendix C

## Practice Location Fact Sheet

**The University of Toledo Insurance Program**  
**The University of Toledo Physician, LLC Provider Enrollment**  
*Fully complete a separate Fact Sheet & Procedure Checklist for each of your practice locations.*  
*(Note: The Procedure Checklist is completed ONLY for physicians)*

1. Practitioner's Name: \_\_\_\_\_
2. Practice Location Name: \_\_\_\_\_
3. Practice Location Address: \_\_\_\_\_
4. Practice Location Phone: \_\_\_\_\_ Fax: \_\_\_\_\_
5. Type of Privileges (as applicable): \_\_\_ Admitting \_\_\_ Non-admitting (Explain \_\_\_\_\_)
- 5a. Approximately how many hours per week will be spent at this location: \_\_\_\_\_

6. Does or are you requesting UTP provide the professional liability insurance coverage at this location? If another insurer provides insurance, please give the name of the insurance company: _____	UT Physicians	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Does or will UTP bill for the services provided at this location? If you use another billing service, please give the name of that billing service: _____	UT Physicians	Yes <input type="checkbox"/> No <input type="checkbox"/>
8. By practicing at this location, is the <b>TEACHING MISSION</b> of UT is supported? Please explain whether you teach students other than medical students, residents/fellows and any other teaching activities: _____	I Do Teaching At Site	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Medical Students	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Residents/Fellows	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Other Students (explain)	Yes <input type="checkbox"/> No <input type="checkbox"/>
9. By practicing at this location, is the <b>RESEARCH MISSION</b> of UT directly supported (e.g. patients will be recruited for clinical/non-clinical trials)? Explain a 'Yes' answer: _____		Yes <input type="checkbox"/> No <input type="checkbox"/>
10. By practicing at this location, is the <b>STRATEGIC MISSION</b> of UT directly supported (e.g. promoting outreach and business growth UPMC or UTP)? Explain a 'Yes' answer: _____		Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>11. The service provided at this location will be [check the appropriate boxes]:</b>		
Inpatient (Hospital)    Yes <input type="checkbox"/> No <input type="checkbox"/>	Clinic/Office            Yes <input type="checkbox"/> No <input type="checkbox"/>	Long Term Care    Yes <input type="checkbox"/> No <input type="checkbox"/>
Outpatient (Hospital)    Yes <input type="checkbox"/> No <input type="checkbox"/>	Emergency Medicine    Yes <input type="checkbox"/> No <input type="checkbox"/>	Other                    Yes <input type="checkbox"/> No <input type="checkbox"/>

12. Additional comments or information about this location:

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3/24/16



# Practice Location Procedure Checklist

(Note: The Procedure Checklist is completed ONLY for physicians)

## The University of Toledo Insurance Program The University of Toledo Physicians, LLC Provider Enrollment

1. Practitioner's Name: \_\_\_\_\_

2. Practice Location Name: \_\_\_\_\_

**Please classify your surgical practice at this indicated location, if applicable:**

<input type="checkbox"/> Abdominal <input type="checkbox"/> Cardiac <input type="checkbox"/> Cardiovascular Disease <input type="checkbox"/> Colon and Rectal <input type="checkbox"/> Emergency Medicine <input type="checkbox"/> Gastric Bypass/Bariatric Surgery <input type="checkbox"/> General <input type="checkbox"/> Gynecological <input type="checkbox"/> Hand	<input type="checkbox"/> Head and Neck <input type="checkbox"/> Laryngology <input type="checkbox"/> Neurology <input type="checkbox"/> Obstetrics <input type="checkbox"/> Normal Deliveries <input type="checkbox"/> C-Sections <input type="checkbox"/> Vaginal Birth after C-Section <input type="checkbox"/> Ophthalmology	<input type="checkbox"/> Orthopedic <input type="checkbox"/> Spine Surgery <input type="checkbox"/> No Spine Surgery <input type="checkbox"/> Otolaryngology <input type="checkbox"/> Otorhinolaryngology <input type="checkbox"/> Including elective cosmetic procedures <input type="checkbox"/> Not including elective cosmetic procedures <input type="checkbox"/> Plastic	<input type="checkbox"/> Podiatry <input type="checkbox"/> Rhinology <input type="checkbox"/> Thoracic _____% of Practice <input type="checkbox"/> Urology <input type="checkbox"/> Vascular _____% of Practice <input type="checkbox"/> Other _____
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**Please check any of the following procedures you want to perform, at this indicated location, under the insurance coverage you are applying for:**

<input type="checkbox"/> Abortion - Elective <input type="checkbox"/> Acupuncture <input type="checkbox"/> Adenoidectomy <input type="checkbox"/> Anesthesia <input type="checkbox"/> Spinal <input type="checkbox"/> Caudal <input type="checkbox"/> Conc. Sedation <input type="checkbox"/> General <input type="checkbox"/> Other <input type="checkbox"/> Angiography <input type="checkbox"/> Angioplasty <input type="checkbox"/> Appendectomy <input type="checkbox"/> Arteriography <input type="checkbox"/> Assist in Major Surgery <input type="checkbox"/> On own patients <input type="checkbox"/> On patients of others <input type="checkbox"/> Blepharoplasty <input type="checkbox"/> Breast Biopsy <input type="checkbox"/> Breast Implant <input type="checkbox"/> Cosmetic _____% of practice <input type="checkbox"/> Reconstructive _____% of practice <input type="checkbox"/> Bronchoscopy <input type="checkbox"/> Chemonucleolysis <input type="checkbox"/> Cholecystectomy <input type="checkbox"/> Cholecystectomy, Laparoscopic <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Cyrosurgery (other than external lesions)	<input type="checkbox"/> Dermatological Procedure <input type="checkbox"/> Chemical Peel <input type="checkbox"/> Chemabrasion <input type="checkbox"/> Dermabrasion <input type="checkbox"/> Fat Transfer <input type="checkbox"/> Hair Transplant <input type="checkbox"/> Silicone Injection <input type="checkbox"/> Tumescent Liposuction <input type="checkbox"/> Other <input type="checkbox"/> Dermatopathology <input type="checkbox"/> D&C <input type="checkbox"/> Encephalography <input type="checkbox"/> Endoscopic laser therapy <input type="checkbox"/> Endoscopy other than Proctoscopy, Sigmoidoscopy, Colonoscopy & Cystoscopy <input type="checkbox"/> ERCP <input type="checkbox"/> Exchange transfusion in newborns <input type="checkbox"/> How many per year? _____ <input type="checkbox"/> Fluoroscopy <input type="checkbox"/> Fracture Reduction <input type="checkbox"/> Open <input type="checkbox"/> Closed <input type="checkbox"/> Gastroscopy <input type="checkbox"/> Hip nailing <input type="checkbox"/> Hyperbaric Medicine <input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Intensive Care for Newborns Within a Tertiary Care Unit <input type="checkbox"/> Laminectomy <input type="checkbox"/> Laparoscopy <input type="checkbox"/> Laser Hair Removal <input type="checkbox"/> Laser Skin Resurfacing <input type="checkbox"/> Laser Surgery <input type="checkbox"/> Left Heart Catheterization <input type="checkbox"/> Liposuction <input type="checkbox"/> Lithotripsy <input type="checkbox"/> Mammography <input type="checkbox"/> Myelography <input type="checkbox"/> Norplant Insertion/Extraction <input type="checkbox"/> Organ Transplant <input type="checkbox"/> Pain Management <input type="checkbox"/> Medication Only <input type="checkbox"/> Dorsal Root Gangliotomy <input type="checkbox"/> Sympathectomy <input type="checkbox"/> Spinal Cord Stimulator <input type="checkbox"/> Implantation/Removal Drug Infused Pump <input type="checkbox"/> Sphenopalatine Lesioning <input type="checkbox"/> Trigeminal Lesioning <input type="checkbox"/> Cordotomy <input type="checkbox"/> Other _____	<input type="checkbox"/> Pedicle Screws for Spinal Surgery <input type="checkbox"/> Permanent Pacemaker <input type="checkbox"/> Polypectomy <input type="checkbox"/> Prenatal Care <input type="checkbox"/> Radiation/X-Ray Therapy <input type="checkbox"/> Radiopaque Dye <input type="checkbox"/> Robotic Surgery <input type="checkbox"/> Scoliosis Surgery <input type="checkbox"/> Shock Therapy <input type="checkbox"/> Spinal Fusion <input type="checkbox"/> Thyroidectomy <input type="checkbox"/> Tonsillectomy <input type="checkbox"/> Tubal ligation <input type="checkbox"/> Vasectomy <input type="checkbox"/> Weight Control _____% of practice <input type="checkbox"/> Gastric Bubble <input type="checkbox"/> Gastric Stapling <input type="checkbox"/> Medications Prescribed: _____ <input type="checkbox"/> Other Procedures (please list): _____ _____ _____
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None of the above procedures are applicable to my practice at this indicated location.

**If applicant is approved for insurance coverage, it will be his/her responsibility to notify The University of Toledo Risk Management Department of any changes in practice specialty, including but not limited to practice location, procedures, affiliation, etc. Failure to notify The University of Toledo Risk Management Department of such changes could require retroactive upward premium adjustment and in the event of a claim, could lead to a denial of liability coverage.**