



# Physicians Health Plan

**Credentialing and  
Re-Credentialing  
Plan**

**This Credentialing and Re-Credentialing Plan may be distributed to applying or participating Licensed Independent Practitioners, Hospitals and Ancillary Providers upon request. Additionally, Health Plan may distribute this document to those entities that have applied for delegation of credentialing.**

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## Section 1

### INTRODUCTION

**Section 1.1 Purpose.** Physicians Health Plan/ PHP Insurance Company/PHP Service Company/PHP Medicare (referred to collectively as "Health Plan") has the sole right to determine which Licensed Independent Practitioners (sometimes referred to in this Plan as "LIPs") and Hospitals and Ancillary Providers (sometimes referred to in this Plan as "HAAPs") it will accept and continue as participating providers.

The purpose of this Credentialing and Re-Credentialing Plan (sometimes referred to as "Credentialing Plan" or "Plan") is to provide a Health Plan policy for credentialing, re-credentialing, limiting the participation of and terminating Participating LIPs/HAAPs who provide care and services to any Covered Person. At a minimum, all Participating LIPs/HAAPs that the Health Plan promotes as part of its network shall be subject to this Plan. In the sole discretion of the Health Plan, other health care professionals and entities may also be subject to the Credentialing Plan.

Decisions and actions of the Health Plan will be guided primarily by (a) consideration of each provider's potential contribution to the Health Plan's primary objective of providing high quality, effective and efficient health care services to the Health Plan's members and customers; and (b) the Health Plan's need for providers within its service area.

In making its credentialing and re-credentialing decisions, the Health Plan will not discriminate on the basis of religion, race, color, national origin, age, gender, sexual orientation, height, weight, familial status, marital status, disability unrelated to the provision of care to Covered Persons, or any other basis prohibited by law. The Health Plan also will not discriminate in credentialing and re-credentialing LIPs/HAAPs based upon the types of procedures (e.g., abortions) or the types of patients (e.g., Medicaid) that the practitioner/provider specializes in provided that such concerns are unrelated to the provision of care to Covered Persons.

All Participating LIPs/HAAPs that the Health Plan promotes as being part of its network shall be subject to this Plan prior to being promoted as part of its network.

The policies and procedures that support this Plan are deemed to be part of this Plan.

**Section 1.2 Discretion, Rights and Changes.** The Health Plan has the sole right to determine which Licensed Independent Practitioners, Hospitals and Ancillary Providers it will accept and maintain within its network. Nothing in this Credentialing Plan limits the Health Plan's discretion to accept, suspend, condition, limit or terminate the participation of Participating Licensed Independent Practitioners, Hospitals and Ancillary Providers. The Credentialing and Peer Review Committee may recommend any action it deems appropriate to improve and monitor performance and to protect the safety of the Health Plan's Covered Persons. The Health Plan will comply with local, state, and federal laws and regulations regarding appeal rights and credentialing/re-credentialing functions. Unless required by law, it is in the sole discretion of the Health Plan as to whether to offer a Participating LIP, Ancillary Provider or Hospital the opportunity to appeal any action taken by the Health Plan under this Credentialing and Re-Credentialing Plan. No portion of this Plan grants rights to Covered Persons. This Credentialing Plan does not limit the Health Plan's rights under its written agreements with Participating LIPs, Ancillary Providers and Hospitals. This Credentialing Plan may be changed without the prior approval of Participating LIP, Ancillary Provider or Hospital when the Health Plan, in its sole discretion, determines there is a need for such modification(s) or revision(s). Changes will be effective for all new and existing LIPs/HAAPs from the effective date of the change.

**Section 1.3 Definitions.** For the purposes of the Plan, the terms listed below have the following meanings and are capitalized throughout this Plan:

- a. **“Ancillary Provider”** includes, but is not limited to, birthing centers, dialysis centers, durable medical equipment providers, home health care providers, hospices, infusion providers, laboratories, outpatient pathology facilities, outpatient radiology facilities, physical therapy facilities, pain management centers, rehabilitation facilities (general and cardiac), sleep centers, skilled nursing facilities, surgical centers, urgent care centers, and behavioral health centers (inpatient, residential and ambulatory).
- b. **“Appeal”** means a request by a Participating Licensed Independent Practitioner, Hospital or Ancillary Provider to reconsider a Professional Competence or Conduct Decision that affects a Licensed Independent Practitioner, Hospital or Ancillary Provider’s participation in the Health Plan’s network of providers.
- c. **“Applicant”** means a Licensed Independent Practitioner, Hospital or Ancillary Provider who has submitted an application to the Health Plan for credentialing or re-credentialing.
- d. **“Benefit Plan”** means a benefit plan that: (i) is issued and/or administered by the Health Plan or an affiliate of the Health Plan; and (ii) contains the terms and conditions of a Covered Person’s coverage.
- e. **“Business or Administrative Related Decision”** means an action or recommendation made by Health Plan that is based upon business or administrative related concerns and that will reduce, restrict, suspend, revoke, or deny a Participating LIP/HAAP’s participation in Health Plan’s network. The Credentialing and Peer Review Committee shall have the discretion to determine those actions or recommendations that constitute a Business or Administrative Related Decision for purposes of this Plan. Any action or recommendation made by Health Plan that is based upon professional competence or conduct is not considered a Business or Administrative Related Decision under this Plan.
- f. **“Clean File”** means a credentialing or re-credentialing file that meets the minimum requirements set forth in this Plan. A Clean File must also have had a Clean File review during initial credentialing or the prior re-credentialing cycle.
- g. **“Covered Person”** means a person who is covered by a Benefit Plan issued, administered or sponsored by the Health Plan (i.e., members, subscribers, insured, participants, enrollees or other Covered Persons).
- h. **“DataBank”** means the Healthcare Integrity and Protection DataBank, the National Practitioner DataBank, and any other information clearinghouse created by Congress with the primary goals of improving health care quality, protecting the public, and reducing health care fraud and abuse in the U.S., collectively.
- i. **“Dispute”** means a request by a Participating Licensed Independent Practitioner, Hospital, or Ancillary Provider to reconsider a Business or Administrative Related Decision that affects a Licensed Independent Practitioner, Hospital, or Ancillary Provider’s participation in the Health Plan’s network of providers.
- j. **“HAAP”** means Hospital and Ancillary Provider or Hospital or Ancillary Provider (see Definitions, “Ancillary Provider” and “Hospital”).
- k. **“High-Risk Office Based Procedure”** means any procedure that may be performed in a Licensed Independent Practitioner office setting that involves the administration of general anesthesia or where there is a risk of patient loss of consciousness, significant bleeding, significant chance for internal organ perforation or cardiovascular collapse (e.g., cardiac stress testing).
- l. **“High-Risk LIP”** means any Licensed Independent Practitioner performing High-Risk Office Based Procedures.

- m. **"High-Volume Specialties"** means any Licensed Independent Practitioner the Health Plan determines, through analysis of administrative claims data, who meets a certain threshold of high-volume as defined by the Health Plan.
- n. **"Hospital"** means an entity which (i) is operated pursuant to applicable law; (ii) is primarily engaged in providing health services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities, by, or under the supervision of, a staff of physicians; (iii) has 24-hour nursing services; (iv) is not primarily a place for rest, custodial care of the aged, or a nursing home, convalescent home or similar institution; (v) may include a "step-down," alternative, or non-acute facility; and (vi) is accredited as a Hospital by The Joint Commission, the Healthcare Facilities Accreditation Program (HFAP) and/or another recognized national certifying entity that has established standards for Hospitals.
- o. **"Licensed Independent Practitioner"** or **"LIP"** means any health care professional who is permitted by law to practice independently within the scope of the individual's license or certification, and includes but is not limited to physicians (MD/DO), dentists, chiropractors, doctors of podiatric medicine, nurse practitioners, psychologists, social workers and certified midwives. Licensed Independent Practitioners subject to the Credentialing and Re-Credentialing Plan are limited to those who are promoted as part of the Health Plan's network.
- p. **"Notice"** means (i) depositing the correspondence in the United States mail, using first class or certified mail, postage prepaid, addressed to the other party at the last known office address given by the party to the other party; or (ii) delivering the correspondence to an overnight courier, delivery to the other party prepaid, addressed to the other party at the last known office address given by the other party, (iii) through facsimile or other electronic transmission (such as email) to the other party at the last known office facsimile number or electronic address given by the party to the other party, or (iv) personally delivering written notice to the other party.
- q. **"Participating LIP/HAAP"** means a Licensed Independent Practitioner, Hospital or Ancillary Provider who has entered into a Participation Agreement with the Health Plan.
- r. **"Participation Agreement"** means an agreement between the Health Plan and a LIP, HAAP that sets forth the terms and conditions under which the LIP, HAAP participates in the Health Plan's network.
- s. **"Professional Competence or Conduct Decision"** means an action or recommendation made by the Health Plan, in the course of reviewing the credentials of a Participating LIP/HAAP that are based upon the professional competence or conduct of such Participating LIP/HAAP, to reduce, restrict, suspend, revoke, or deny a Participating LIP/HAAP's participation in the Health Plan's network.

## Section 2

### **BOARD OF DIRECTORS, COMMITTEES, AND MEDICAL DIRECTOR**

**Section 2.1 Board of Directors.** The Health Plan's Board of Directors (the "Board") has the ultimate responsibility for the administration of the Credentialing Plan. The Board has given the Quality Committee the authority to delegate (a) the function of administering this Credentialing Plan to the Health Plan's Credentialing and Peer Review Committee; and (b) all or part of its credentialing responsibilities to a health care delivery organization or other entity whose credentialing program meets the standards of the Health Plan. The Board has established the Credentialing and Peer Review Committee as a standing committee. The Board has (a) elected the Health Plan's Chief Executive Officer (CEO) or other individual with authority over the Health Plan operations to serve as Chairperson of the Quality Committee; and (b)

delegated the authority to the CEO or other officer with authority over the Health Plan operations to appoint the Credentialing and Peer Review Committee members.

**Section 2.2 Quality Committee.** The Quality Committee shall make reports at least semi-annually to the Board. The Quality Committee hereby delegates this reporting function to the Credentialing and Peer Review Committee. These reports must be in writing and must summarize credentialing, re-credentialing, and delegated entity activities that have occurred since the previous report. The Board shall either approve these reports or make recommendations that must be implemented by the Health Plan.

**Section 2.3 Credentialing and Peer Review Committee.** The Credentialing and Peer Review Committee is a standing committee established by the Board of Directors. The Credentialing and Peer Review Committee must be composed of a Health Plan's Medical Director (or his/her physician designee[s]) and representatives of the medical community). The Credentialing and Peer Review Committee (i) administers the Credentialing Plan on behalf of the Health Plan; (ii) discusses whether Participating LIPs/HAAPs are meeting acceptable conduct standards (iii) accesses appropriate clinical peer input when discussing acceptable conduct for a particular type of provider; (iv) provides guidance to Health Plan staff on the overall direction of the Health Plan's credentialing and re-credentialing; (v) reports to the Board of Directors and Health Plan management on the effectiveness of the Health Plan's credentialing and re-credentialing program; (vi) approves or disapproves applications for participation; (vii) maintains minutes of all committee meetings and documents all actions; (viii) meets monthly as necessary to fulfill its responsibilities; and (ix) performs any other duties necessary to further the Health Plan's credentialing and re-credentialing program. For clean files described in Section 3.4 (a), Medical Director Review of Clean Files, the date the Medical Director reviewed and approved the clean file shall be the date an Applicant is considered eligible to participate as a Participating LIP/HAAP of the Health Plan's network. For files that are not considered clean, the date the Credentialing and Peer Review Committee takes action shall be the date that an Applicant is considered eligible to participate as a Participating LIP/HAAP of the Health Plan's network. For all files, the date the Credentialing and Peer Review Committee takes action shall serve as the date for determining the timeliness of all requirements for credentialing and re-credentialing as set forth in the Credentialing Plan. The Credentialing and Peer Review Committee shall be comprised of at least five (5) Participating LIPs, including the Health Plan's Medical Director. At a minimum, one participating LIP shall have no other role in the Health Plan management.

**Section 2.4 Appeal Committee.** For each time that a Health Plan grants a Participating LIP/HAAP's request to a First Level Appeal of a Professional Competence or Conduct Decision, the Health Plan shall appoint a First Level Appeal Committee. Such First Level Appeal Committee will conduct the hearing in accordance with this Plan. Each First Level Appeal Committee shall consist of at least three (3) qualified individuals, of which at least one (1) must be a Participating LIP who is not otherwise in Health Plan management and who is a clinical peer of the appealing Participating LIP and who has comparable levels of education and training as the appealing Participating LIP/HAAP. The First Level Appeal Committee cannot be comprised of any individuals who (i) are in direct economic competition with the appealing Participating LIP/HAAP; (ii) are in business with the appealing Participating LIP/HAAP; or (iii) have previously made a recommendation or decision regarding the appealing Participating LIP/HAAP's participation in the Health Plan network. Mere knowledge of the matter at issue in an appeal hearing will not preclude any individual from serving as a member of a First Level Appeal Committee.

**Section 2.5 Medical Director.** The Medical Director shall be responsible (a) for the operation of the Credentialing Plan; and (b) for those other credentialing activities as defined by the Health Plan. The Medical Director may delegate some of the operational functions of the Credentialing Plan to an associate Medical Director.

**Section 2.6 Credentialing Staff.** The Credentialing staff is responsible for ensuring the quality of the provider network through the credentialing/re-credentialing process. The Credentialing Coordinator is

responsible for (a) the confidential collection, tracking, recording and monitoring of data required in the credentialing/re-credentialing process; (b) accurate, clear, and concise external communication to providers and their staff; (c) ensures all new and existing applicants meet administrative criteria for participation with the Plan, (d) reviews, compiles, verifies and processes all incoming information submitted by new and existing applicants in compliance with the credentialing standards developed and outlined in the Plan's credentialing policies and procedures; (e) notifies applicants of missing information; (f) ensures that all credentialing/re-credentialing steps are performed in compliance with Accreditation standards, State and PHP guidelines and that all providers are credentialed according to required timeframes (g) maintains the confidentiality of all data collected, (h) prepares materials for presentation to the Credentialing and Peer Review Committee, (i) recording and maintenance of all committee meeting minutes and documentations.

### Section 3

#### INITIAL CREDENTIALING OF LICENSED INDEPENDENT PRACTITIONER APPLICANTS

##### Section 3.1 Initial Credentialing: Application.

- a. Consideration of New Applications. Except as otherwise required by law, the Health Plan may allow LIPs with an expressed interest in participating with the Health Plan to apply for participation status if the Health Plan determines it needs additional LIPs and/or that other organizational needs may be satisfied by including additional LIPs in its network. However, each Applicant shall have the burden of producing adequate information for the Health Plan to conduct a proper evaluation of his/her experience, professional ethics/background, training, demonstrated ability, physical and mental status, and of resolving any doubts about these or any other qualifications for approval. Applicant shall have the obligation to continually update his/her Application with the most current information available. Failure to so update the Application shall constitute grounds for the Health Plan's denial of the Application.
- b. Application Form. Each Applicant must complete an application form that includes:
  - 1) An unlimited release, upon a form prescribed by the Health Plan, granting the Health Plan permission to review the records of and to contact any professional society, hospital, DataBank, insurance company, present or past employer, professional peer review organizations, clinical instructor, or other person, entity, institution or organization that does or may have records or professional information about the Applicant.
  - 2) A release, upon a form prescribed by the Health Plan, from legal liability for any such person, entity, institution or organization that provides information as part of the application process or that requests information from the Health Plan that the Health Plan obtained during the application process for peer review purposes.
  - 3) A copy of the Applicant's current professional license(s) or certification(s).
  - 4) A statement that a report may be submitted to the appropriate state licensing board or DataBank, if the Health Plan rejects the application for reasons requiring such a report.
  - 5) A copy of the Applicant's current Drug Enforcement Agency ("DEA") or Controlled Dangerous Substance Certificate ("CDS"), if applicable.
  - 6) The Applicant's professional liability claims history that resulted in settlements or judgments paid by or on behalf of the Applicant, and history of liability insurance coverage including any refusals or denials to cover Applicant or any cancellations of coverage.
  - 7) Educational history and degrees received relevant to the Applicant's area of practice, licensure or certification, including dates of receipt.



- 8) A listing of degrees or certifications received from appropriate professional schools, residency training programs or other specialty training programs appropriate for the type of participation sought, if applicable.
- 9) A listing of professional licenses received, whether current or expiring and licensing history, including any challenges, restrictions, conditions or other disciplinary action taken against such license or voluntary relinquishment of such licensure.
- 10) Current certifications, where such certification is required for participation in Medicare or Medicaid or other federal programs and certification history for such participation, including restrictions, conditions or other disciplinary action.
- 11) Criminal felony or misdemeanor convictions, or civil judgments that involved dishonesty, fraud, deceit or misrepresentation.
- 12) Employment history, including history of voluntary or involuntary terminations from employment or professional disciplinary action or other sanction by a managed care plan, hospital, other health care delivery setting, medical review board, licensing board or other administrative body or government agency.
- 13) A signed statement attesting to:
  - (a) Applicant's current professional liability insurance policy, including the name of the insurer, policy number, expiration date and coverage limits;
  - (b) Limitations on Applicant's ability to perform functions of the position with or without accommodation;
  - (c) History of loss, restriction, or limitation of Applicant's privileges or disciplinary activity taken against Applicant;
  - (d) Absence of current, illegal drug use;
  - (e) Completeness and accuracy of the information provided in the application.
- 14) Current on-call coverage assignments, if required by the Health Plan.
- 15) A list of High-Risk Procedures that the Applicant may perform in an office setting.
- 16) Authorization to allow the Health Plan to conduct a review, satisfactory to the Health Plan, of Applicant's practice, including office visits, staff interviews and medical records reviews.
- 17) Any other documents or information that the Health Plan determines are necessary for the Health Plan to effectively and/or efficiently review the Applicant's qualifications.

**Section 3.2 Applicant.** Applicant is responsible for the timely completion of the Application, providing all requested information, and disclosing all facts that the Health Plan desires to consider in making a credentialing decision regarding the Applicant. Applicants and Participating LIP/HAAPs must inform the Health Plan of any material change to the information on an Application submitted on their behalf. The Health Plan must be immediately informed of any change involving:

- a. The revocation, suspension, restriction, curtailment, probation, or limitation, whether voluntary or involuntary, of the Applicant’s professional license or certification by any state licensing agency;
- b. The revocation, suspension, restriction, curtailment, probation, or limitation, whether voluntary or involuntary, of the Applicant’s medical staff membership or clinical privileges at any hospital or other health care institution;
- c. The cancellation, termination, restriction, probation, limitation, or other curtailment, whether voluntary or involuntary, of the Applicant’s status as a participating provider in any managed care organization, network, or preferred provider organization;
- d. The cancellation, non-renewal, or restriction of Applicant’s professional liability insurance coverage;
- e. The revocation, suspension, or voluntary relinquishment of any registration at the state, federal, or district level, which allows Applicant to prescribe any medications;
- f. Any adverse action reported by a peer review organization concerning Applicant’s quality of care;
- g. The commencement of any formal investigation or the filing of any charges by the Department of Health and Human Services or any law enforcement agency or health care regulatory agency of the United States or any state;
- h. The filing of any lawsuit or the assertion of any claim against the Applicant alleging professional liability;
- i. Any change in Applicant’s Office of Inspector General (OIG) sanction status or General Services Administration (GSA) department status; or
- j. Any change in Applicant’s ability to provide Covered Services to Health Plan Covered Persons.
- k. Any change in Applicant’s exclusion from participation in any federal or state program, including, without limitation, Medicare under Sections 1128 or 1128A of the Social Security Act.

Failure to inform the Health Plan of a status change, as described above, may result in the administrative denial of Applicant’s Application.

**Section 3.3 Credentialing Criteria of New LIP Applicants.**

- a. Minimum Administrative Requirements. Before forwarding an application to the Credentialing and Peer Review Committee, the Health Plan’s credentialing staff will collect information to assess whether the Applicant meets the Health Plan’s minimum administrative requirements for participation. Additional requirements may be added as a result of Health Plan action. The minimum administrative requirements include, but are not limited to, the following:
  - 1) A graduate degree if the Applicant is a physician (M.D., D.O.), from an acceptable school of medicine or osteopathy, listed in the current AAMC Directory of American Medical Education, published by the American Association of Medical Colleges, or in the current World Directory of Medical Schools, published by the World Health Organization or confirmation from the Education Commission for Foreign Medical Graduates (“ECFMG”) for international medical graduates licensed after 1986. A graduate degree from an accredited advanced dental education program, as identified by the American Dental

Association, if the applicant is a dentist. If the Applicant is not a physician or dentist, an appropriate graduate degree for the Applicant's license or certification is required;

- 2) A post-graduate training program appropriate for the type of participation sought, if applicable, as determined by the Health Plan;
  - 3) Current licensure or certification without limitations, restrictions, conditions or other disciplinary action taken against the Applicant's license to practice the Applicant's profession in the state(s) included in the Health Plan's service area and where the Applicant practices. Conditions such as probation for continuing education, limitations or other actions that do not have an impact on the practitioner performing services, may be considered exempt at the discretion of the Medical Director or the Credentialing and Peer Review Committee, as applicable.
  - 4) Current and valid DEA or CDS Certificate, unless the Applicant's practice does not require it;
  - 5) Current certification, where such certification is required, in the Medicare and/or Medicaid or other federal programs, if determined necessary or desirable by the Health Plan, and/or participation without restriction, conditions or other history of disciplinary action or sanctions taken against Applicant;
  - 6) Active staff privileges at a participating hospital or arrangements with a Participating LIP or hospitalist to admit Covered Persons, if the Health Plan determines, in its sole discretion, that Applicant's practice requires such privileges;
  - 7) Practice location and specialty that meets the Health Plan's needs, as determined by the Health Plan in its sole discretion;
  - 8) A level of liability insurance or remaining level of policy coverage that meets the minimum limits established by the Health Plan;
  - 9) Adequate on-call coverage back-up by a like LIP who is or will be a Participating LIP, if applicable and required by the Health Plan;
  - 10) The Applicant must not have been denied initial participation or had participation terminated (for reasons other than network need) by the Health Plan or any Newly Merged Network within the preceding 24 months. The Applicant's attestation is sufficient verification of this requirement;
  - 11) Agreement to allow the Health Plan to conduct a review, satisfactory to the Health Plan, of the Applicant's practice, including office visits, staff interviews and medical record reviews;
  - 12) Absence of a history of denial or cancellation of professional liability insurance warranting denial of participation status;
  - 13) Absence of current exclusion or debarment from participation in Medicare, Medicaid or other state or federal health care programs, including the OIG and the GSA.
  - 14) Absence of criminal history of conviction or guilty pleas to felonies or misdemeanors related to qualifications, or misdemeanors involving violence or other occurrences that would raise questions of undesirable conduct.
- b. Verification of Credentials. The Health Plan must verify the credentials listed below through an acceptable primary source. Primary sources may include the state licensing board, school/residency/training program, board certification via the AMA Master File, AOA Master File,

the Educational Commission for Foreign Graduates, or special board of registry. The Health Plan may use oral, written or Internet data to verify the following credentials of Applicants:

- 1) Current valid license to practice or certification, as minimally required to engage in clinical practice;
  - 2) Highest level of medical or professional education and training (i.e., M.D. and D.O. graduation from medical school and completion of residency; D.C. graduation from chiropractic college; D.D.S. graduation from dental school and completion of specialty training, as applicable; D.P.M. graduation from podiatry school and completion of hospital residency program; N.P. Master's degree in nursing, as applicable, PA, graduate degree from an Accreditation Review Commission on Education approved program). If Applicant is Board Certified, primary source verification of each level of education and training is not required if the certifying board primary source verifies education and training. The Health Plan must primary source verify Board Certification as indicated in Section 3.2.b.3 below;
  - 3) Board certification if the LIP states that he/she is board certified on application.
- c. DataBank Inquiry: Before forwarding an application to the Credentialing and Peer Review Committee, the Health Plan's credentialing staff must verify information about the Applicant through a review of the DataBank. The DataBank's information will be forwarded to the Credentialing and Peer Review Committee.
- d. Sanction Inquiry. The Health Plan must obtain and review sanction information reported by state medical boards, the Department of Health and Human Services, OIG, and GSA and any other fraud and abuse sanctions reported by other applicable federal or state agencies. The Health Plan may access sanction information, including fraud and abuse sanctions, from the Sanction Database or any credible source, unless required by law to obtain such information from a different source.
- e. Verification Time Limit. All information requiring verification must have been verified within 180 days from the date accompanying the Applicant's signature to the date the Credentialing and Peer Review Committee makes its decision. All application information requiring the Applicant's attestation as to the correctness and completeness of the information, must have been signed by the Applicant within 180 days from the date that the Credentialing and Peer Review Committee makes its decision.
- f. Action on Completed Application. If Health Plan staff determines, in its sole discretion, that an application is complete and meets the minimum administrative requirements for participation and that the Applicant's site visit, if applicable, is complete the Health Plan will forward the application to the Credentialing and Peer Review Committee.
- g. Incomplete Application. If the application fails to meet minimum administrative requirements for participation or is incomplete, the Health Plan's credentialing staff, in its sole discretion, may (1) inform the Applicant that the application for participation has been rejected; (2) request the missing information; or (3) forward the application to the Credentialing and Peer Review Committee for review and consideration.

### **Section 3.4 Medical Director/Credentialing and Peer Review Committee Review of New LIP Applicants.**

- a. Medical Director Review of Clean Files. The Medical Director is the individual with authority to deem a file to be a Clean File and to sign off on the Clean File as complete and approved, subject to the final approval of the Credentialing and Peer Review Committee. The Medical Director must present to the Credentialing and Peer Review Committee a list of those Clean Files that the Medical Director desires be approved by the Credentialing and Peer Review Committee and solicit from the Credentialing and Peer Review Committee any discussion regarding such Clean Files. The

Credentialing and Peer Review Committee, in its discretion, may request additional information on, or the opportunity to review, any Clean File. In addition, the Medical Director, at his/her sole discretion, may recommend that a Clean File be reviewed by the Credentialing and Peer Review Committee. The minutes of the Credentialing and Peer Review Committee meetings must document the discussion and if applicable, the final approval of any Clean Files.

- 1) If a Clean File receives final approval from the Credentialing and Peer Review Committee, the Clean File will be considered to be approved effective the date that the Medical Director reviewed and approved the Clean File.
- b. Credentialing and Peer Review Committee Review Criteria for Files that are not Considered Clean. Upon receipt of an application from Health Plan credentialing staff, the Credentialing and Peer Review Committee will determine whether the Applicant's file contains evidence of any of the following and shall consider such factors in determining to accept, limit, restrict or deny the Applicant's participation:
- 1) Conduct that violates state or federal law or standards of ethical conduct governing the Applicant's profession;
  - 2) Felony convictions or other acts involving dishonesty, fraud, deceit or misrepresentation;
  - 3) History of involuntary termination of professional employment for reasons that would warrant the restriction or denial of participation status;
  - 4) History of professional disciplinary action or other sanction by a managed care plan, hospital, medical review board, licensing board or other administrative body or government agency including either OIG sanctions regarding Medicare or Medicaid participation or GSA debarments for reasons that would warrant the restriction or denial of participation status;
  - 5) A DataBank Adverse Action Report that reveals conditions that would warrant the restriction or denial of participation status;
  - 6) Misrepresentation, misstatement or omission of a relevant fact on the application;
  - 7) History of the wasteful or irresponsible use of medical resources (e.g., over utilization of medical procedures when compared to peers); or
  - 8) History of quality of care concerns, malpractice lawsuits, judgments or settlements;
  - 9) History of persistent billing errors, abusive billing practices, or poor service.
- c. Additional Considerations. In making its decision, the Credentialing and Peer Review Committee shall also determine whether the Applicant demonstrates the following:
- 1) Ability to practice to the full extent of the Applicant's professional license and qualifications without a risk to patient safety or health;
  - 2) Willingness to practice within the Health Plan's network and to cooperate with Health Plan's administrative procedures;
  - 3) Practice that is oriented toward clinically sound, proven or otherwise appropriate modalities of treatment, as determined by the Health Plan in its sole discretion; and
  - 4) Practice that is primarily oriented to providing the types of health care services covered under Health Plan's Benefit Plans.
- d. Credentialing and Peer Review Committee Action. The Credentialing and Peer Review Committee has the authority to approve or disapprove applications. The Credentialing and Peer Review

Committee may base its decision on any factors it deems appropriate, whether or not these factors are mentioned in this Credentialing Plan.

In reviewing an application, the Credentialing and Peer Review Committee may request further information from the Applicant. The Credentialing and Peer Review Committee may table an application pending the outcome of an investigation of the Applicant by a hospital, licensing board, governmental agency or any other organization or institution; may table an applicant for legal review; or may recommend any other action it deems appropriate including, but not limited to, obtaining a third party's review of an Applicant's application. The date the Credentialing and Peer Review Committee approves or disapproves an application shall be the date the Applicant is considered eligible to participate as a LIP of the Health Plan's network and shall also serve as the date for determining the timeliness of all requirements for credentialing as set forth in the Credentialing Plan.

A summary of the decisions of the Credentialing and Peer Review Committee, including the numbers and types of providers is forwarded to the Quality Committee and the Health Plan's Board of Directors for notification. Upon request from the Quality Committee or the Board of Directors, detailed decisions of the Credentialing and Peer Review Committee will be provided. New LIP Applicants who do not have Participation Agreements with the Health Plan or who are applying under a group, facility or other participation agreement requiring individual completion of credentialing may not appeal the Credentialing and Peer Review Committee's decision to deny or disapprove such New LIP's Application for participation with the Health Plan. Any acceptance of the Applicant is conditioned upon the Applicant's agreement to accept the Health Plan's terms and conditions of participation. Acceptance of an Applicant does not create a contract between the Applicant and the Health Plan.

Applicants will be notified of Committee decision, including but not limited to, acceptance without restrictions, acceptance with restrictions, pending with requests for additional information, suspension, denials, or terminations within ten (10) business days of decision.

## **Section 4**

### **RE-CREDENTIALING OF PARTICIPATING LICENSED INDEPENDENT PRACTITIONERS**

**Section 4.1 Re-Credentialing Participating LIPs: Application.** At least once every 36 months, the Health Plan will review Participating LIPs for continued participation in the network. Participating LIPs will be sent a re-credentialing application by the Health Plan or will complete another entity's or organization's re-credentialing application, which the Health Plan, in its sole discretion, accepts. Each Applicant must complete an application as outlined in Section 3.1.b. The completed application must be returned within the time frames established by the Health Plan. Participating LIP shall have the obligation to continually update his/her application with the most current information available and notify the Health Plan upon the occurrence of those events described in Section 6 of this Plan. Failure to so update the application will constitute grounds for denial of the re-credentialing application and termination of Participating LIP's participation status.

#### **Section 4.2 Re-Credentialing Criteria of LIPs.**

- a. Minimum Administrative Requirements For Continued Participation. Before forwarding the re-credentialing application to the Credentialing and Peer Review Committee, Health Plan's staff will determine whether a Participating LIP continues to meet the administrative minimum requirements for participation. Additional requirements may be added as a result of Health Plan action. The minimum administrative requirements for participation and the following criteria:
  - 1) All of those criteria set forth in Section 3.2 a-j and Section 3.3;

- 2) Pattern of referral primarily to Participating LIPs/HAAPs;
  - 3) Practice that is oriented toward clinically sound, proven or otherwise appropriate modalities of treatment, as determined by the Health Plan in its sole discretion;
  - 4) Practice that is primarily oriented to providing the types of health care services covered under the Health Plan's benefit contracts and/or of the type for which the Health Plan is providing or arranging administrative and/or managed care services;
  - 5) Absence of a history of persistent billing errors, abusive billing practices, wasteful or irresponsible use of medical resources, and poor service warranting denial of participation status;
  - 6) Cooperation with the Health Plan to conduct reviews, satisfactory to the Health Plan, of the Participating LIP's practice, including office visits, staff interviews and medical record reviews;
  - 7) Absence of a history of denial or cancellation of professional liability insurance warranting denial of participation status;
  - 8) Willingness to evaluate and improve clinical performance relative to credible benchmarks and the performance of peers; and
  - 9) Willingness to participate in the Health Plan's quality improvement activities.
- b. Site Visit and Medical Record Content Assessment. If Health Plan staff determines that the Participating LIP meets the Health Plan's criteria requiring a site visit (as more fully described in the immediately following paragraph), an assessment of the Participating LIP's office site and content of medical records may be conducted as part of periodic or ongoing monitoring. Site visits may be conducted through an on-site visit by the Health Plan's qualified staff or designee using a tool designed and/or approved by the Health Plan.
- Site visits may be a result of periodic or expeditious monitoring of LIP offices identified by the following: LIP or practice specific written or verbal member complaints about quality of care, safety, site condition or concerns about office administrative practices including medical record keeping practices or confidentiality issues. Site visits will be conducted at LIP offices that meet the threshold of three (3) or more such complaints in a rolling 12-month period. Site visits may also be conducted by Health Plan for other reasons, as determined by Health Plan, in its sole discretion. The site visit will be performed within 60 calendar days of the complaint threshold being met.
- All site visit criteria set forth by the Health Plan must be available for review by the Health Plan and must be satisfied for the re-credentialing application to be considered complete.
- c. Incomplete Re-Credentialing Application or Unsatisfactory Site Visit. Health Plan staff may take any action on re-credentialing applications with incomplete information or an unsatisfactory site visit as set forth in Section 3.3.g.
  - d. Action on Completed Re-Credentialing Application. Re-Credentialing applications shall be forwarded to the Health Plan's Credentialing and Peer Review Committee as set forth in Section 3.4.

#### **Section 4.3 Credentialing and Peer Review Committee Review of Participating LIPs.**

- a. Credentialing and Peer Review Committee Review Criteria. The Credentialing and Peer Review Committee, in considering the re-credentialing application of a Participating LIP will first review whether the Participating LIP meets the requirements set forth in Section 3.2 and 3.3. In addition to the review categories listed in Sections 4.1 and 4.2, the Credentialing and Peer Review Committee

will evaluate Participating LIPs to determine: (1) if the Participating LIP meets criteria for continued participation; or (2) if the Participating LIP rises to the level of “distinguished clinician,” and/or (3) if the Participating LIP could benefit from some form of education or other performance improvement support:

Review Categories may include but are not limited to:

- 1) Clinical contribution to the health and wellbeing of members and communities;
- 2) Patient relations including Covered Person’s complaints or dissatisfaction;
- 3) Continuing medical education;
- 4) Clinical efficacy;
- 5) Clinical efficiency and appropriateness;
- 6) Medical outcomes;
- 7) Performance improvement;
- 8) Peer recognition;
- 9) Citizenship and ethics;
- 10) Medical liability.

- b. Credentialing and Peer Review Committee Action. The Credentialing and Peer Review Committee has the authority to approve or disapprove re-credentialing applications and to take any appropriate action, including acceptance of applications with or without restrictions or rejection of applications. The Credentialing and Peer Review Committee may base its decision on factors it deems appropriate, whether or not these factors are mentioned in this Credentialing Plan.

In reviewing an application for re-credentialing, the Credentialing and Peer Review Committee may request further information from the Participating LIP. The Credentialing and Peer Review Committee may table a re-credentialing application pending the outcome of an investigation of the Participating LIP by a hospital, licensing board, government agency or any other organization or institution; may table a re-credentialing application for legal review, or the Credentialing and Peer Review Committee may take any other action it deems appropriate, including but not limited to, obtaining a third party’s review of an Applicant’s re-credentialing application. The date the Credentialing and Peer Review Committee takes action shall be the date the Applicant is considered eligible to participate as a LIP of the Health Plan’s network and shall also serve as the date for determining the timeliness of all requirements for re-credentialing as set forth in the Credentialing Plan. A summary of the decisions of the Credentialing and Peer Review Committee are forwarded to the Quality Committee and Health Plan’s Board of Directors for notification. Upon request from the Quality Committee or the Board of Directors, detailed decisions of the Credentialing and Peer Review Committee will be provided.

Decisions to take action on or terminate a Participating LIP subject to any appeal offered to and accepted by the Participating LIP will also be reported to the Quality Committee and Health Plan’s Board of Directors for notification. Acceptance of a Participating LIP’s application for re-credentialing is conditioned upon the Participating LIP’s agreement to accept Health Plan’s terms and conditions of participation. Acceptance of the re-credentialing application does not constitute renewal of an underlying Participation Agreement between the LIP and the Health Plan.

## **Section 5**



## **CONFIDENTIALITY AND APPLICANT RIGHTS**

**Section 5.1 Confidentiality of Applicant and Participating LIP Information.** The Health Plan acknowledges the confidential nature of certain information obtained in the credentialing process. To protect this information, the Health Plan will maintain an internal mechanism, which limits the review of confidential information in the Health Plan's credentialing files to (1) Health Plan's Medical Director(s); (2) members of the Credentialing and Peer Review Committee; (3) members of the Quality Committee; (4) members of First and Second Level Appeal Committees; (5) Health Plan's credentialing staff; (6) the members of the Board of Directors; and (7) authorized representatives of the Health Plan. All information collected during the credentialing/re-credentialing process is kept confidential either through locked cabinets or password protected electronic access. In addition, the Health Plan will contractually require entities to which it delegates any credentialing function(s) to maintain the confidentiality of this information. Notwithstanding the above, the Health Plan will release information obtained in the credentialing process to entities and/or individuals, as required by law from time to time. Credentialing staff, including any temporary personnel and credentialing committee members are trained on confidentiality policies and procedures. A copy of the applicable policy and procedures are provided. All committee members and credentialing staff sign a confidentiality and conflict of interest statement that is kept on file. Health Plan staff also receive annual training on confidentiality through the Health System annual compliance module trainings.

### **Section 5.2 Applicant Rights.**

- a. Review of Information. The Health Plan acknowledges that Applicants and Participating LIPs have the right to review certain information submitted in connection with their credentialing or re-credentialing application, including information received from any primary source, and to submit information to correct erroneous information that has been obtained by the Health Plan to evaluate the application. Applicants also have the right to obtain information about the status of their Application. The Health Plan is not required to allow an Applicant to review personal or professional references or other information that is peer review protected or is otherwise prohibited from disclosure by law. The Health Plan will notify the Applicant in writing within thirty (30) days of identification of information that varies substantially from the information provided by the Applicant. The Applicant must review the information and submit any proposed corrections in writing to the Health Plan within thirty (30) days of the Applicant's notification by the Health Plan. The Health Plan will then review the information submitted by Applicant to determine whether a correction is warranted.
- b. DataBank and State Licensing Reporting. The Health Plan will notify the LIP/HAAP that a report will be submitted to the appropriate state licensing board and/or the DataBank if the Health Plan takes any action requiring such a report or for other actions taken by the Health Plan requiring such a report.
- c. Required Reporting of Adverse Credentialing Decisions. The Health Plan is required by state and federal law to report certain various professional review actions taken against LIPs to the applicable state licensure boards, and the DataBank. Therefore, upon taking a professional review action that adversely affects an LIP, the Health Plan will also determine the legal reporting obligations it has and make such reports in conformance with the applicable law. In addition, as required by state and federal law, the Health Plan may be required to provide other health care providers, associations, peer review entities, etc. with information regarding any adverse credentialing decisions made by the Health Plan, which arise from the Health Plan's professional review activities.

## **Section 6**

## **ON-GOING MONITORING**

### **Section 6.1 Participating LIP Updates.**

- a. It remains the responsibility of the Participating LIP to inform the Health Plan of any material change of information supplied to the Health Plan between re-credentialing cycles. Failure to inform the Health Plan of a status change may result in immediate suspension or termination from the Health Plan's network. Specifically, a Participating LIP shall immediately notify the Health Plan upon the occurrence of any of the following:
- 1) The revocation, suspension, restriction, curtailment, probation, or limitation, whether voluntary or involuntary, of the Participating LIP's professional license by any state licensing agency;
  - 2) The revocation, suspension, restriction, curtailment, probation, or limitation, whether voluntary or involuntary, of Participating LIP's medical staff membership or clinical privileges at any hospital or other health care institution;
  - 3) The cancellation, termination, restriction, probation, limitation, or other curtailment, whether voluntary or involuntary, of Participating LIP's status as a participating provider in any managed care organization, network, or preferred provider organization;
  - 4) The cancellation, non-renewal, or restriction of Participating LIP's professional liability insurance coverage;
  - 5) The revocation, suspension, or voluntary relinquishment of any registration at the state, federal, or district level, which allows Participating LIP to prescribe any medications;
  - 6) Any adverse determination by a peer review organization concerning Participating LIP's quality of care;
  - 7) The commencement of any formal investigation or the filing of any charges by the Department of Health and Human Services or any law enforcement agency or health care regulatory agency of the United States or any state;
  - 8) The filing of any lawsuit or the assertion of any claim against the Participating LIP alleging professional liability;
  - 9) Any change in Applicant's OIG sanction status or GSA department status; or
  - 10) Any change in Applicant's ability to provide Covered Services to Health Plan Covered Persons.
  - 11) Any change in Applicant's exclusion from participation in any federal or state program, including, without limitation, Medicare under Sections 1128 or 1128A of the Social Security Act.

Failure to inform the Health Plan of a status change, as described above, may result in immediate suspension or termination from the Health Plan's network.

- b. **On-Going Monitoring.** As Participating LIPs, Ancillary Providers and Hospitals are credentialed, they will be reviewed for the following information:
- 1) License to practice, if such license was due to expire during that quarter. An updated license or verification of a current license must be verified by the Health Plan within 60 days of the expiration date.
  - 2) State and Federal reports will be reviewed monthly or within thirty (30) days of their release to identify Participating LIPs, Ancillary Providers or Hospitals who may have had OIG sanctions on Medicare or Medicaid participation, GSA debarments, or other sanctions

against their license or certification. If the State of Michigan’s report is not available monthly, the Health Plan will review the reports at the frequency with which they are produced and made available by the State.

If the Health Plan identifies a license that has not been renewed, an OIG sanction on Medicare or Medicaid participation, GSA debarment, or other sanction against a license or certification, action shall be taken as outlined in Section 9.

- 3) Potential quality concerns, including but not limited to complaints or dissatisfaction from Health Plan Staff or Covered Persons, office site assessments or medical record content assessments that do not meet Health Plan defined standards. If quality concerns are identified, action shall be taken as outlined in Section 8 or Section 9.

## Section 7

### HOSPITAL AND ANCILLARY PROVIDER CREDENTIALING

**Section 7.1 Criteria for Credentialing Hospitals and Ancillary Providers.** Before forwarding an application to the Credentialing and Peer Review Committee, the Health Plan’s credentialing staff will collect information to assess whether the HAAP meets the Health Plan’s administrative requirements for participation. Additional requirements may be added as a result of Health Plan action. The minimum administrative requirements include, but are not limited to the following:

- a. Organization is in good standing with the state and federal regulatory bodies;
- b. Absence of a history of sanctions or other actions through a review of DataBank reports warranting denial of participation status;
- a. Absence of debarment from participation in Medicare, Medicaid or other state or federal health care programs including the OIG and GSA warranting denial of participation status;
- b. Organization has current, applicable and required state license(s) verified;
- c. Organization has required level of liability insurance acceptable to Health Plan standard;
- d. Organization has accreditation or certification, as appropriate (see table or list below);

FACILITY	CRITERIA
Ambulance	CAAS, State Agency Certification
Audiology, Speech, and Language Pathology facilities	URAC
Behavioral Health Centers (inpatient, residential and ambulatory)	Joint Commission or CARF
Birthing Centers	AAAHC
Durable Medical Equipment or Prosthetic Companies	CHAPS, Joint Commission or ABCPO, but no certification or accreditation required. No on-site visit required for credentialing of these facilities.
Home Health Care, Hospice	CHAPS, Joint Commission, State Agency Certification
Hospitals	*Required accreditation: Joint Commission, HFAP, AAAHC or Det Norske Veritas Healthcare Inc.
Infusion Company	CHAPS or Joint Commission
Labs	CLIA, COLA, CHAPS, Joint Commission or CMS

FACILITY	CRITERIA
Occupational or Physical Therapy Centers	<i>On-site visit, Joint Commissions, CARF, AAAASF, or other acceptable certifying or accrediting agency (if applicable)</i>
Outpatient/Freestanding Radiology	ACR, Joint Commission or AAAHC
Pain Management Centers, Sleep Centers, Dialysis Centers	On-site visit, AASM, NDAC or acceptable certifying or accrediting agency (if applicable),
Rehabilitation Centers: General Cardiac	CARF, HFAP, Joint Commission or AAAHC
Skilled Nursing Facility	CARF, CHAPS, Joint Commissions, State Agency Certification
Substance Abuse Facilities	*Required accreditation: COA, HFAP, CARF, or Joint Commission
Surgical Centers	AAAASF, AOS, Joint Commission or AAAHC
Urgent Care Centers	HFAP or Joint Commission or AAAHC

Acceptable Accreditation and Certification Entities List :

- AAAASF (American Association for Accreditation of Ambulatory Surgery Facilities)
- AAAHC (Accreditation Association for Ambulatory Health Care)
- AASM (American Academy of Sleep Medicine)
- ABCPO (American Board for Certification of Prosthetics and Orthotics)
- ACR (American College of Radiology)
- CAAS (Commission of Accreditation on Ambulance Services)
- CAP (College of American Pathologists)
- CARF (Commission on Accreditation of Rehabilitation Facilities)
- CHAPS (Community Health Accreditation Program)
- CLIA (Clinical Laboratory Improvement Amendment certification)  
Certification required not just CLIA license
- CMS (Centers for Medicare and Medicaid Services)
- COLA (Commission on Office Laboratory Accreditation)
- COA Council on Accreditation
- HFAP Healthcare Facilities Accreditation Program
- JC The Joint Commission
- NCQA National Committee for Quality Assurance
- NDAC National Dialysis Accreditation Commission
- State Agency Facility must have received an on-site visit with certification within the past 3 years. Health Plan's Reviewer and Medical Director must have reviewed and approved the State Agency's Certification process prior to accepting such certification in lieu of an on-site visit by the Health Plan.
- URAC URAC

**Section 7.2 Organizations Not Accredited or Certified.** If the Organization is not accredited or not certified by an agency recognized by the Health Plan, a site review of the organization is required and results must be found to be satisfactory as defined by the Health Plan. The Health Plan may substitute a CMS or state review in lieu of the required site visit. The Health Plan must obtain the report from the institution to verify that the review has been performed and that the report meets the Health Plans standards. A letter from CMS or the applicable state agency which shows that the facility was reviewed and indicates that it passed inspection is acceptable in lieu of the survey report if the Health Plan reviewed and approved CMS or state criteria as meeting the Health Plans standards. Durable Medical Equipment and Prosthetic Companies are not required to have accreditation or certification and may be exempt from the site visit requirement.

The following minimum criteria must be reviewed and found to be satisfactory as defined by the Health Plan at the time of the site visit:

- Physical accessibility to the building, exam rooms and bathrooms, including accommodations for the handicapped;
- Physical appearance to provide a safe, clean environment for patients, visitors and staff;
- Adequacy of waiting and exam room space including provisions for privacy during examinations or procedures;
- Safety of clinical equipment including logs of regular inspections and training of staff;
- Safety of medication administration including logs for samples and assessing expiration dates of medications;
- Availability of appointments;
- Office staffing including the numbers, qualifications, competence and training of clinical staff;
- Credentialing process for those organizations that credential their LIPs;
- Process to privilege those organizational LIPs that perform high-risk procedures; and
- CLIA and/or ACR certification, if lab and/or radiology services are provided in the office.

Any organization that does not meet the criteria as set forth in 7.1 and 7.2 should not be approved for participation unless there is a specific need for the organization in the network as defined by the Health Plan.

**Section 7.3 Medical Director.** The Medical Director shall review the HAAPs file prior to presentation to the Credentialing and Peer Review Committee. The date the Credentialing and Peer Review Committee makes the final decision shall be the date the HAAP is considered eligible to participate in the Health Plan's network and shall also serve as the date for determining the timeliness of all requirements for credentialing and re-credentialing as set forth in the Credentialing Plan. The Credentialing and Peer Review Committee will determine final decision for the approval or denial of HAAPs.

**Section 7.4 Credentialing and Peer Review Committee Responsibilities.** The Credentialing and Peer Review Committee may approve or deny HAAPs. The date the Credentialing and Peer Review Committee takes such action shall be the date the Applicant is considered eligible to participate in the Health Plan's network and shall also serve as the date for determining the timeliness of all requirements for credentialing and re-credentialing as set forth in the Credentialing Plan.

**Section 7.5 Re-Credentialing of a Hospital or Ancillary Provider.** A HAAP shall be re-credentialed at least once every 36 months. In addition to the review criteria set forth in Sections 7.1 and 7.2, the following information may be evaluated prior to making a re-credentialing decision:

- a. Patient relations including Covered Person's complaints or dissatisfaction;

- b. Clinical efficacy, efficiency and appropriateness of treatment; and
- c. Quality improvement activities.

Participating HAAP shall have the obligation to continually update its application with the most current information available and to notify the Health Plan upon occurrence of those events described in Section 7.1 of this Plan. Failure to so update the application will constitute grounds for denial of the re-credentialing application and termination of the Participating HAAP.

## Section 8

### LICENSED INDEPENDENT PRACTITIONERS, ANCILLARY PROVIDERS AND HOSPITALS COMPLIANCE IMPROVEMENT WORK PLAN

**Section 8.1 Credentialing and Peer Review Committee.** At any time, the Credentialing and Peer Review Committee in its sole discretion may identify and recommend education or other support for a Participating LIP/HAAP who demonstrates inadequate compliance with the requirements set forth in the Credentialing Plan. These recommendations may be initiated on the basis of any information the Credentialing and Peer Review Committee deems appropriate. These recommendations shall be incorporated into a written Compliance Improvement Work Plan (sometimes referred to as “Work Plan”). The Participating LIP/HAAP shall be given an opportunity to voluntarily work with Health Plan staff in developing and implementing the Work Plan. In the event that Health Plan staff and the Participating LIP/HAAP are unable to agree on a Work Plan, the matter shall be referred back to the Credentialing and Peer Review Committee for further action.

**Section 8.2 Work Plan.** The Credentialing and Peer Review Committee may recommend any action to be incorporated in the Work Plan that it deems appropriate to improve and monitor the LIP/HAAP’s, noncompliance with this Credentialing Plan. These recommended actions may include but are not limited to the following:

- a. Supplying the LIP/HAAP with clinical guidelines, quality improvement "tools" and techniques, benchmarking information, or other reference materials;
- b. Monitoring the LIP/HAAP for a specified period of time, followed by a Credentialing and Peer Review Committee determination about whether the inadequate compliance has been corrected;
- c. Requiring the Participating LIP/HAAP staff to use peer consultation for specified types of care;
- d. Requiring the Participating LIP/HAAP staff to obtain training in specified types of care.

**Section 8.3 Failure to Cooperate.** If the Participating LIP/HAAP fails to cooperate with Health Plan staff in developing and/or implementing a Work Plan, Health Plan staff shall so advise the Credentialing and Peer Review Committee and shall refer the matter to the Credentialing and Peer Review Committee for further action.

## Section 9

### DENIAL, SUSPENSION, RESTRICTION, AND TERMINATION OF PARTICIPATION OF LIP/HAAP

**Section 9.1 Immediate Suspension or Restriction.** Notwithstanding the procedures set forth in Sections 7 and 8, if a Health Plan Medical Director (or his/her designee) determines in his/her sole discretion that the health and safety of any Health Plan Covered Person is in imminent danger because of the actions or inaction of a Participating LIP/HAAP or that, in his/her opinion, because a Participating LIP/HAAP may be subject to termination, pursuant to this Credentialing Plan, the Medical Director may immediately suspend

or restrict such LIP/HAAP's participation status during which time the Health Plan will investigate on an expedited basis to determine if further action is required. The Health Plan, in its sole discretion, may take steps necessary to notify those Health Plan Covered Persons who regularly obtain health services from or who are assigned to such suspended Participating LIP/HAAP of the fact that the Participating LIP/HAAP has been suspended by the Health Plan and that such suspension means that until further notice, suspended Participating LIP/HAAP will not be reimbursed for providing services to Health Plan Covered Persons effective immediately. Reasons for suspension include, but are not limited to:

- a. Failure to comply with the minimum requirements for participation set forth in this Credentialing Plan;
- b. Failure to adhere to the terms of the Participating LIP/HAAP Participation Agreement;
- c. Concern(s) for patient safety and/or quality of care substantiated with documentation; or
- d. Concerns regarding unprofessional conduct, substantiated with documentation.

If a Participating LIP/HAAP's suspension is considered by the Credentialing and Peer Review Committee to be a Professional Competence or Conduct Decision, then such Participating LIP/HAAP shall have the right to appeal such suspension pursuant to Section 11 of this Plan. If a Participating LIP/HAAP's suspension is considered by the Credentialing and Peer Review Committee to be a Business or Administrative Related Decision, then such Participating LIP/HAAP shall have the right to dispute such suspension pursuant to Section 12 of this Plan.

**Section 9.2 Medicare and Medicaid Sanction.** The Health Plan shall review the Medicare and Medicaid Sanction, Exclusion and Reinstatement Report (sometimes referred to as "the Report") issued by the Centers for Medicare and Medicaid Services and the Office of Inspector General on a monthly basis. Any Participating LIP/HAAP listed on the report as sanctioned or excluded shall be immediately terminated from the Health Plan's network. Any Applicant who has an application pending the Health Plan's approval and who the Health Plan discovers during such application process is listed on the Report as sanctioned or excluded will be immediately denied participating provider status. Such decision shall not be subject to any appeal or dispute resolution process.

**Section 9.3 Business or Administrative Related Decisions.** The Health Plan, in its sole discretion, may administratively deny, restrict, suspend, or terminate the participation of any Participating LIP/HAAP without referring the matter to the Credentialing and Peer Review Committee. Reasons for administrative denials and terminations include, but are not limited to (a) failure to notify the Health Plan of a status change as required by Section 6.1 of this Credentialing Plan; (b) a failure to comply with the administrative requirements set forth in Section 3 and Section 4 of this Credentialing Plan; (c) failure to adhere to the terms of the Participation Agreement; (d) a change in the organizational structure following a merger or acquisition or change in the products offered by the Health Plan; (e) the suspension or restriction of the participation of any Participating LIP/HAAP that was based upon a Business or Administrative Related reason for longer than twelve (12) months; and (f) change in the Health Plan's need for a LIP/HAAP given a reduction in the size of membership. Participating LIPs/HAAPs who are denied or terminated by the Health Plan as a result of Business or Administrative Related Decisions reasons may be entitled to the appeal rights described in Section 12 of this Plan but shall not have the right to appeal such Business or Administrative Related Decisions under Section 11 of this Plan. The right to appeal a Business or Administrative Related Decision under Section 12 of this Plan applies exclusively to Participating LIP/HAAPs. An Applicant who does not have a Participation Agreement in place with the Health Plan at the time of such Applicant's application has no appeal rights under this Plan.

**Section 9.4 Credentialing and Peer Review Committee Review.** The Credentialing and Peer Review Committee in its sole discretion may deny participation status to an Applicant or terminate the participation of a Participating LIP/HAAP. Consideration of a denial or termination may be initiated by any condition the Credentialing and Peer Review Committee deems appropriate, including but not limited to the following:

- a. The Participating LIP/HAAP fails to meet one or more of the administrative requirements or professional criteria listed in this Plan, including but not limited to Sections 3.2, 3.3, 4.2 and 4.3 of this Plan;
- b. The medical care and service a Participating LIP/HAAP delivers to Health Plan Covered Persons is harmful, potentially harmful, offensive, unnecessary or inefficient;
- c. The Participating LIP/HAAP engages in abusive, fraudulent, or persistent erroneous billing practices that impact or could impact any payor, including but not limited to the submission of claims for payments that are false, misleading, incorrect or duplicated;
- d. The Participating LIP/HAAP failed to comply with Health Plan policies and/or procedures, including, but not limited to those for medical management, credentialing/re-credentialing, quality improvement, member rights or billing; or
- e. The Participating LIP/HAAP engages in uncooperative, unprofessional or abusive behavior toward Health Plan personnel.

## Section 10

### PROCEDURES FOR DENIAL, SUSPENSION, RESTRICTION AND TERMINATION OF PARTICIPATION

**Section 10.1 General Nature of the Termination Process.** The termination procedures set forth in Sections 9, 10, 11, and 12, guide the process involved in denying, suspending, restricting and terminating an Applicant's or Participating LIP/HAAP's participation status. The Health Plan, the Credentialing and Peer Review Committee and the Quality Committee, in their sole discretion, may follow the procedure set out below or they may use alternative procedures they deem appropriate, or are otherwise required by federal, state, or local law.

**Section 10.2 Review by Credentialing and Peer Review Committee.** If the Health Plan receives information that appears to warrant a Professional Competence or Conduct Decision or a Business or Administrative Related Decision, the Health Plan will compile pertinent information and refer the matter to the Credentialing and Peer Review Committee. If the Credentialing and Peer Review Committee directly receives information relating to a Participating LIP/HAAP, that it believes, in its sole discretion, suggests that a Professional Competence or Conduct Decision or a Business or Administrative Related Decision may be appropriate, the Credentialing and Peer Review Committee may ask the Health Plan staff to investigate the matter.

If the Credentialing and Peer Review Committee believes that further information is needed, it may obtain such information from the Participating LIP, or other sources. The Credentialing and Peer Review Committee may request or permit the Participating LIP to appear before the Credentialing and Peer Review Committee to discuss any issue relevant to the investigation. The Credentialing and Peer Review Committee will consider the information received and determine whether a denial, disciplinary action, restriction, suspension or termination is appropriate. The Credentialing and Peer Review Committee has complete discretion in denying participation to an Applicant or the restriction, suspension, or termination of a Participating LIP's participation status and may base its recommendation on any factors it deems appropriate. The Credentialing and Peer Review Committee's denial of an Applicant and the suspension, restriction and/or termination of a Participating LIP will be forwarded to the Health Plan's Quality Committee for notification.

**Section 10.3 Appeal of Professional Competence or Conduct Decision.** If the Credentialing and Peer Review Committee makes a Professional Competence or Conduct Decision with regard to a Participating LIP's participation status and the Credentialing and Peer Review Committee offers such Participating LIP an opportunity to appeal the recommendation, the Credentialing and Peer Review Committee will provide



the Participating LIP written notice of the Credentialing and Peer Review Committee's recommendation, that (1) states the specific criteria, facts and circumstances that the Credentialing and Peer Review Committee considered in making its recommendation; (2) specifies the proposed effective date of the recommended disciplinary action or termination; (3) summarizes the basis for the Credentialing and Peer Review Committee's recommendation; (4) describes the Participating LIP's right to request a hearing to appeal the recommendation; (5) sets forth the time limit within which to request such a hearing; and (6) generally describes the appeal process and summarizes the Participating LIP's rights during the hearing. The appeal process shall be conducted in accordance with the appeal procedures set out in Section 11. The rights to appeal a Professional Competence or Conduct Decision under Section 11 of this Plan apply exclusively to Participating LIP/HAAPs. An Applicant who does not have a Participation Agreement in place with Health Plan at the time of such Applicant's application has no appeal rights under this Plan.

**10.4 Appeal of Business or Administrative Related Decision.** If the Credentialing and Peer Review Committee makes a Business or Administrative Related Decision with regard to a Participating LIP's participation status, the Credentialing and Peer Review Committee may offer such Participating LIP an opportunity to dispute the recommendation. The Credentialing and Peer Review Committee will provide the Participating LIP written notice of the Credentialing and Peer Review Committee's recommendation, that (1) states the specific criteria, facts and circumstances that the Credentialing and Peer Review Committee considered in making the Business or Administrative Related Decision; (2) specifies the proposed effective date of the Business or Administrative Related Decision; (3) summarizes the basis for the Credentialing and Peer Review Committee's Business or Administrative Related Decision; (4) describes the Participating LIP's right to request an informal dispute resolution meeting to discuss the Business or Administrative Related Decision; (5) sets forth the time limit within which to request such a meeting; and (6) generally describes the dispute resolution process. The dispute resolution process shall be the procedure set forth in Section 12. The right to dispute a Business or Administrative Related Decision under Section 12 of this Plan applies exclusively to Participating LIP/HAAPs. An Applicant who does not have a Participation Agreement in place with Health Plan at the time of such Applicant's application has no dispute resolution rights under this Plan.

## **Section 11**

### **APPEAL PROCEDURES APPLICABLE TO PROFESSIONAL COMPETENCE OR CONDUCT DECISIONS**

**Section 11.1 Appeal of Professional Competence or Conduct Decision.** If the Credentialing and Peer Review Committee makes a Professional Competence or Conduct Decision with regard to a Participating LIP/HAAP, the Credentialing and Peer Review Committee shall offer the Participating LIP/HAAP an opportunity to appeal the Professional Competence or Conduct Decision. A Participating LIP/HAAP shall have two (2) levels of appeals: (i) the First Level Appeal; and (ii) the Second Level Appeal. The procedures described in this Section 11 apply exclusively to First and Second Level Appeals of Professional Competence or Conduct Decisions and are afforded exclusively to Participating LIPs/HAAPs. An Applicant who does not have a Participation Agreement in place with Health Plan at the time of such Applicant's application has no appeal rights under this Plan.

**Section 11.2 First Level Appeal of Professional Competence or Conduct Decision.** To initiate the appeal process described in this Section 11, a Participating LIP/HAAP has the right to a First Level Appeal. A Participating LIP/HAAP must exhaust the First Level Appeal process prior to requesting a Second Level Appeal. The First Level Appeal process is described below.

**Section 11.3 Second Level Appeal of Professional Competence or Conduct Decision.** If a Professional Competence or Conduct Decision is upheld by the First Level Appeal Committee at the First Level Appeal, a Participating LIP/HAAP has the right to a Second Level Appeal. The Second Level Appeal process is described below. Once a Participating LIP/HAAP completes the Second Level Appeal described herein, the

Participating LIP/HAAP will have exhausted all of his or her approval rights, and the Professional Competence or Conduct Decision shall be final, unless otherwise overruled by the Health Plan.

**Section 11.4 First Level Appeal Procedures.** The procedures set forth in this Section 11.4 shall apply to First Level Appeals.

**a. Request for First Level Appeal.** If the Credentialing and Peer Review Committee offers the Participating LIP/HAAP an opportunity to appeal a Professional Competence or Conduct Decision at the First Level, the Participating LIP/HAAP must request a hearing in writing. The request for such appeal must be received by the Health Plan within thirty (30) days of the date that the notice of such appeal rights was sent to the Participating LIP/HAAP. The Participating LIP/HAAP shall be deemed to have forfeited and waived his or her appeal rights if he or she does not submit a timely written request for an appeal of the Professional Competence and Conduct Decision, and the Professional Competence or Conduct Decision shall become final.

**b. Chairperson.** The Health Plan shall appoint a First Level Appeal Committee pursuant to Section 2.4. The First Level Appeal Committee shall follow the procedures set forth below. The appeal hearing shall be live to the extent feasible but may be held through other means as designated by the Credentialing and Peer Review Committee when deemed necessary by the Credentialing and Peer Review Committee. The Health Plan's Medical Director will select one member of the First Level Appeal Committee to serve as Chairperson. The Chairperson of the First Level Appeal Committee will (1) be required to make him/herself familiar with the provisions of this Credentialing Plan applicable to the appeal process; (2) lead the appeal hearing; (3) orchestrate any follow-up meetings, beyond the appeal hearing amongst the First Level Appeal Committee members necessary for the First Level Appeal Committee to render a decision on the appeal; (4) ensure that the First Level Appeal Committee provides to the Health Plan and the appealing Participating LIP/HAAP a written decision regarding the appeal; and (5) perform any other duties assigned by the Medical Director to the First Level Appeal Committee.

**c. Scheduling and Notice.** Upon receipt of a Participating LIP/HAAP's timely written appeal request, the Health Plan's credentialing staff will notify the Participating LIP/HAAP that an appeal will be scheduled and that the Health Plan will provide further information when a hearing date is set. If an appeal cannot be scheduled within four (4) months of the date such notice due to the unavailability of the Participating LIP/HAAP (or his/her representative) or due to the action or inaction of the Participating LIP/HAAP, the request for the appeal will be considered withdrawn and the Professional Competence or Conduct Decision will be considered final and effective. The appeal hearing will be scheduled before the recommended action becomes effective, except in the case of an immediate suspension, restriction or termination, as provided in Section 9.1.

When a hearing is scheduled, the Health Plan will provide a written hearing notice to the appealing Participating LIP/HAAP, stating:

1. The time, place and date of the hearing;
2. A list of the witnesses and consultants, if any, expected to be called by the Health Plan at the hearing; and
3. The composition of the First Level Appeal Committee.

Within five (5) days of Participating LIP/HAAP's receipt of this notice, the Participating LIP/HAAP may object to any First Level Appeal Committee member. The objection must be in writing stating the basis for the objection. The decision as to whether to replace any First Level Appeal Committee member will be at the sole discretion of the Medical Director.

The scheduled hearing date may not be less than thirty (30) days from the date the appealing Participating LIP/HAAP is sent notice of the hearing, unless the parties mutually agree upon a shorter notice period. Absent extenuating circumstances, the hearing shall take place within four (4) months from the date the

appealing Participating LIP/HAAP requested the appeal, or the Health Plan shall have the right to schedule the appeal hearing at a date beyond such period described herein if the Health Plan, in its sole discretion, determines that the circumstances warrant such an extension.

**d. Pre-Hearing Matters.** Generally, both the Health Plan and the appealing Participating LIP/HAAP under review will each be afforded the opportunity to exchange and examine exhibits before the hearing. If requested by either party or at the direction of the Chairperson, copies of the exhibits will be exchanged by the parties no later than five (5) business days before the date of the hearing. Additional exhibits can only be introduced upon a showing of good cause as determined by the Chairperson and at the written agreement of both parties. The First Level Appeal Committee shall not consider when making its decision: any exhibits exchanged four (4) days or fewer prior to the hearing; unless the Chairperson has determined a party has shown good cause to introduce the exhibit, and both parties have agreed in writing to the introduction of the exhibit. The Health Plan will provide the First Level Appeal Committee with a copy of the letter to the appealing Participating LIP/HAAP notifying him or her of the recommended action and a copy of the appealing Participating LIP/HAAP's written response, if any. The parties shall also exchange in writing the names of witnesses to be called no later than three (3) business days before the date of the hearing, and witnesses shall be subject to the limitations in Section 11.7(e) below. Additional witnesses can only be called upon a showing of good cause as determined by the Chairperson and at the agreement of both parties. Only the individuals on the witness list will be allowed to attend the hearing unless the Chairperson determines there is good cause for the individual to be present and the parties agree on the record for that individual to be present.

**e. The Hearing.**

1. Failure to Appear. The personal presence of the appealing Participating LIP/HAAP is required. Participating LIP/HAAP shall be deemed to have forfeited his or her right to the appeal hearing if the Participating LIP/HAAP fails to appear at the hearing without good cause, which shall be determined by the Credentialing and Peer Review Committee.
2. Representation. The appealing Participating LIP/HAAP and the Health Plan may be represented by counsel or another person of their choice. The appealing Participating LIP/HAAP must advise the Health Plan at least fifteen (15) days prior to the hearing of the identity of counsel appearing on his/her behalf at the hearing. If a party is represented by an attorney or anyone else, that attorney or person will be responsible for presenting the case.
3. Record. A record shall be made of the hearing; the Health Plan may arrange for a court reporter to provide an official record of the hearing or arrange for an audio taped record to be made of the hearing. If a court reporter is present at the hearing, the court reporter will name the parties present and, as necessary, identify their representatives. The reporter will swear in all witnesses, record all oral testimony and mark and maintain the documents submitted as exhibits. Following the hearing and upon the request of either party, the reporter will provide a copy of the written transcript to each of the parties and the First Level Appeal Committee. The Health Plan and the Participating LIP/HAAP shall each pay one half of the court reporter's fee; each party shall be provided a copy of the transcript. Alternatively, if the Health Plan does not arrange for a court reporter, it will arrange for an audio taped record to be made of the hearing. Copies of this record will be made available to the appealing Participating LIP/HAAP upon payment of a reasonable charge.
4. Chairperson. The Chairperson of the First Level Appeal Committee will preside at the appeal hearing. The Chairperson will determine the order of procedure and will make all rulings on procedure, including postponements and recesses, and the admissibility of evidence. The

Chairperson may, in his or her sole discretion, call a pre-hearing conference in order to make decisions regarding any procedural matters.

5. Rights of Parties. During the hearing, each of the parties will have the right (i) to call and examine witnesses; (ii) to introduce exhibits; (iii) to cross-examine any witness on any matter relevant to the issues; (iv) to rebut any evidence; and (v) to submit a written statement at the close of the hearing. Oral evidence will be taken only on oath or affirmation administered by a person entitled to notarize documents.
6. Presentation of Evidence by the Health Plan. The Health Plan may first present any oral testimony or written evidence it wants the First Level Appeal Committee to consider. The appealing Participating LIP/HAAP or his or her representative will have the opportunity to cross-examine any witness testifying on the Health Plan's behalf.
7. Presentation of Evidence by Appealing LIP/HAAP. After the Health Plan submits its evidence, the appealing Participating LIP/HAAP may present evidence to rebut or explain the situation or events described by the Health Plan. The Health Plan will have the opportunity to cross-examine any witness testifying on the appealing Participating LIP/HAAP's behalf. Character witness testimony shall be provided by written affidavit only, and shall be subject to the disclosure timeline in Section 11(d) above.
8. Health Plan Rebuttal. The Health Plan may present additional witnesses or written evidence to rebut the appealing Participating LIP/HAAP. The appealing Participating LIP/HAAP will have the opportunity to cross-examine any additional witnesses testifying on the Health Plan's behalf.
9. Time. The presentation of evidence, testimony and questions shall be limited to a three (3) hour period, at which time the hearing shall be adjourned by the Chairperson and resumed at a time mutually agreeable to First Level Appeal Committee and the parties. Any extension of time or any adjournment or any additional time needed for testimony will require a showing of good cause as determined by the Chairperson, and the agreement of both parties.
10. Summary Statement. After the parties have submitted their evidence, both the Health Plan and the appealing Participating LIP/HAAP will have the opportunity to make a brief closing statement. The Health Plan shall first make a brief closing statement, followed by the appealing Participating LIP/HAAP. In addition, the parties will have the opportunity to submit written statements to the First Level Appeal Committee. The First Level Appeal Committee will establish a reasonable time frame for the submission of such statements. Each party submitting a written statement must provide a copy of the statement to the other party or the other party's legal counsel, if applicable.
11. Examination by First Level Appeal Committee. Throughout the hearing, the First Level Appeal Committee may question any witness who testifies.

**f. Evidentiary Standards.** The evidence must reasonably relate to the specific issues or matters involved in the recommended action. The First Level Appeal Committee has the right to refuse to consider evidence that it deems irrelevant or otherwise unnecessary to consider. The rules of evidence applicable in a court of law do not apply. A party who objects to the presentation of any evidence must state the grounds for the objection and the First Level Appeal Committee shall determine whether the evidence will be admitted. The First Level Appeal Committee will determine the relative weight to be given to various items of evidence submitted.

**g. First Level Appeal Committee Decision.**

1. Standard of Review. The Health Plan will have the initial obligation to present evidence in support of its recommendation. The appealing Participating LIP/HAAP requesting the hearing will have the burden of persuading the First Level Appeal Committee that the Health Plan's recommendation lacks substantial factual basis, or is unreasonable, arbitrary or capricious.

2. Review of Evidence and Vote. After the hearing and receipt of written summary statements, the First Level Appeal Committee will convene and privately discuss the Credentialing and Peer Review Committee's recommendation. The First Level Appeal Committee may recommend to uphold, reject, or modify the Professional Competence or Conduct Decision. The First Level Appeal Committee's decision will be based upon the evidence First Level Appeal Committee.
3. Decision of the First Level Appeal Committee. The appealing Participating LIP/HAAP, will be notified in writing in a format prescribed by the Health Plan, of the First Level Appeal Committee's Decision. Such notice will include a statement of the basis and specific reasons for the First Level Appeal Committee's Decision. First Level Appeal Committee Decisions for First Level Appeals shall include a statement describing the Participating LIP/HAAP's Second Level Appeal rights.

**h. Notification and Effective Date of Action.** Written notice of the Professional Competence or Conduct Decision will be given to the appealing Participating LIP in an expeditious and appropriate manner and will include a statement of the basis of the decision. Unless a Participating LIP/HAAP submits a request for a Second Level Appeal, such decision will be effective immediately. If a Participating LIP/HAAP waives his or her appeal rights under this Section, such decision will be effective as of the date that the Participating LIP/HAAP is deemed by the Health Plan to have waived his or her appeal rights

**Section 11.5 Second Level of Appeal.** The procedures set forth in this Section 11.5 shall apply to Second Level Appeals.

**a. Request for Second Level of Appeal.** Within thirty (30) days after receipt of notice of the First Level Appeal Decision, the Participating LIP/HAAP may request a Second Level Appeal before the Second Level Appeal Committee. Such request must be made in writing. The Participating LIP/HAAP shall be deemed to have forfeited and waived his or her Second Level of Appeal if the Participating LIP/HAAP does not submit a timely written request for a Second Level of Appeal, and the First Level Appeal Decision shall become final and immediately effective.

**b. Second Level Appeal Committee.** The Chairperson of the Health Plan's Quality Committee or the Chairperson's designee (referred to as "Chairperson of the Quality Committee") will appoint a Second Level Appeal Committee composed of not less than three (3) persons to consider the record upon which the First Level Appeal Decision ("First Level Appeal Record") was made. At least one member of the Second Level Appeal Committee must be a Participating LIP/HAAP who is not otherwise involved in Health Plan management and who is a clinical peer of the appealing Participating LIP/HAAP. Any individual who participated in making the Professional Competence or Conduct Decision at issue at any lower level may not serve on the Second Level Appeal Committee. Furthermore, no one in direct economic competition or professionally associated with the Participating LIP/HAAP, will be appointed to the Second Level Appeal Committee. Knowledge of the matter involved will not preclude any individual from serving as a member of the Second Level Appeal Committee.

**c. Scheduling and Notice.** Upon receipt of a Participating LIP/HAAP's timely written request for a Second Level Appeal, the Chairperson of the Quality Committee shall, within thirty (30) days after receipt of such request, schedule and arrange for a Second Level Appeal review. The Second Level Appeal Committee shall convene a meeting to review the First Level Appeal Record within sixty (60) days from the date of receipt of the Participating LIP/HAAP's request for the Second Level Appeal. The time for a Second Level Appeal Review may be extended by the Chairperson of the Compliance Council for good cause. When the Second Level of Appeal Review is scheduled, the Health Plan will provide written notice to the appealing Participating LIP/HAAP, stating:

1. The date upon which the Second Level Appeal Committee will review the First Level Appeal Record;
2. A description of the Second Level Appeal Review procedures; and

3. The composition of the Second Level Appeal Committee.

Within five (5) days of Participating LIP/HAAP's receipt of the notice described above, the Participating LIP/HAAP may object to any Second Level Appeal Committee member. The objection must be in writing stating the basis for the objection. The decision as to whether to replace any Second Level Appeal Committee member will be at the sole discretion of the Chairperson of the Quality Committee.

**d. Second Level Appeal Review Procedures**

1. Nature of Review. The Second Level Appeal Committee will conduct a review of the First Level Appeal Record which shall be deemed to consist of the transcript, exhibits, and written statements by the parties.
2. Presiding Officer. The Chairperson of the Compliance Council shall select an individual to serve as the chairperson of the Second Level Appeal Committee. The Chairperson of the Second Level Appeal Committee will coordinate the Second Level Appeal Committee's review of the First Level Appeal Record.
3. Written Statements. In advance of the Second Level Appeal Committee's review, the parties may submit written position statements detailing the findings of fact, conclusions, and procedural matters with which the Participating LIP/HAAP disagrees. The statement must be submitted to the Second Level Appeal Committee through the Chairperson of the Quality Committee at least seven (7) days prior to the scheduled date of the Second Level Appeal Committee's review, except if such time limit is waived by the Second Level Appeal Committee. These written statements may cover any matters raised at any step in the appeal process.
4. Presence of Committee Members and Vote. A majority of the Second Level Appeal Committee must be present throughout the review and deliberations. If a member of the Second Level Appeal Committee is absent from any part of the proceedings, such member will not be permitted to participate in the deliberations or decision.
5. Standard of Review. The Second Level Appeal Committee shall review the First Level Appeal Decision to determine whether it is arbitrary or capricious.
6. Decision of Second Level Appeal Committee. If the Second Level Appeal Committee decides that the First Level Appeal Decision is not arbitrary or capricious, the Second Level Appeal Committee will recommend that the First Level Appeal Decision be affirmed. If the Second Level Appeal Committee decides that the First Level Appeal Decision was arbitrary or capricious, the Second Level Appeal Committee will recommend either: (a) remand of the First Level Appeal Decision for a further hearing; or (2) modification of the First Level Appeal Decision so it is no longer arbitrary or capricious. The Second Level Appeal Committee's Decision will be provided, in writing, to the Chairperson of the Quality Committee.
7. Timing and Notice of Decision. Within thirty (30) days after receipt of the Second Level Appeal Committee Decision, the Quality Committee will affirm, modify, or reverse the Second Level Appeal Committee or, at its discretion, refer the matter back to the Second Level Appeal Committee for further review and recommendation. The Quality Committee decision will be final and conclusive of the matter. The Quality Committee decision will be in writing, and the Quality Committee will deliver copies thereof to the Participating LIP/HAAP.

**Section 11.6 Notifications.**

1. Covered Person Notification. If a Participating LIP's participation is terminated or otherwise limited, the Health Plan will notify the members who regularly obtain health services from or who are assigned to the Participating LIP.

2. Other Notifications. The Health Plan, when deemed by the Health Plan as appropriate and when required, will notify any entities or organizations that have delegated credentialing functions to the Health Plan of a Professional Competence or Conduct Decision related to a Participating LIP. When required by law, the Health Plan shall also notify any regulatory agencies, licensing authorities, databanks, healthcare providers, etc. of a Professional Competence or Conduct Decision related to a Participating LIP/HAAP.

**Section 11.7 Special Circumstances** State or federal regulations may dictate a modification of the procedures outlined above. The Health Plan staff should consult with legal counsel to determine whether special circumstances exist that require modification of the appeal procedures.

## **Section 12**

### **DISPUTE RESOLUTION PROCEDURE APPLICABLE TO BUSINESS OR ADMINISTRATIVE RELATED DECISIONS**

**Section 12.1 Dispute of Business or Administrative Related Decisions.** If the Credentialing and Peer Review Committee or Health Plan makes a decision that it deems to Business or Administrative Related Decision with regard to a Participating LIP/HAAP, the Credentialing and Peer Review Committee shall offer the Participating LIP/HAAP an opportunity to dispute the Business or Administrative Related Decision through an informal meeting. The procedures described in this Section 12 apply exclusively to Business or Administrative Related Decisions and are afforded exclusively to Participating LIPs/HAAPs. An Applicant who does not have a Participation Agreement in place with Health Plan at the time of such Applicant's application has no dispute resolution rights under this Plan. The Health Plan will not deem terminations of a Participating LIP/HAAP's participation status to be a Business or Administrative Related Decision subject to this dispute resolution process for Participating LIP/HAAP's whose participation is terminated based on explicit, objective terms of the Participation Agreement (including but not limited to loss of license or the failure to maintain required professional liability insurance).

**Section 12.2 Dispute Resolution Procedure.** If the Health Plan offers an informal dispute resolution meeting related to a Business or Administrative Related Decision and a Participating LIP/HAAP desires to exercise such right to discuss a Business or Administrative Related Decision, the dispute must be submitted in writing to Medical Director within thirty (30) days of Participating LIP/HAAP's receipt of a letter from the Health Plan notifying the Participating LIP/HAAP of the Business or Administrative Related Decision.

**Section 12.3 Scheduling and Notice.** Upon receipt of a Participating LIP/HAAP's request for a meeting, the Medical Director will schedule the meeting with an authorized representative of the Plan, not previously involved in the initial decision that is subject to dispute, which may include the Medical Director. In no event will the meeting be scheduled for later than thirty (30) days after the Participating LIP/HAAP's request for a meeting is received, unless otherwise agreed to by the parties, or at the sole discretion of the Medical Director, for good cause. If the informal dispute resolution meeting regarding a Business or Administrative Decision cannot be scheduled within sixty (60) days after the date of Participation of LIP/HAAP's request for such meeting due to the unavailability of the Participating LIP/HAAP or due to the action or inaction of the Participating LIP/HAAP (or his or her representative), the request for an informal dispute resolution meeting will be considered withdrawn and the Business or Administrative Related Decision will be considered final and effective. The Medical Director will send a letter to the Participating LIP/HAAP confirming the date, time, and place of such meeting. The Participating LIP/HAAP shall have the burden of establishing that the Participating LIP/HAAP meets the standards for Health Plan participation.

**Section 12.4 Dispute Resolution Meeting.** During the meeting, the Medical Director/authorized representative of the plan and the Participating LIP/HAAP will discuss the reason or reasons for the action.

This is an informal meeting and not a hearing or Appeal. The following procedural requirements shall apply: (i) personal presence will be required; (ii) failure of the provider to appear at the meeting without good cause will constitute a waiver of the right to the meeting and a voluntary acceptance of the action involved; (iii) representation of the provider by legal counsel or any other individual is not permitted, unless such representation is approved in advance of the meeting by a Medical Director; and (iv) the provider may submit any documents and other evidence or written statement to the Medical Director, either before, during, or after the meeting.

**Section 12.5 Medical Director/Representative Decision.** No later than fourteen (14) days after the meeting, the Medical Director/Representative will make a decision regarding the action. The Medical Director will report his or her decision to the Health Plan's CEO. The Medical Director will, within seven (7) days after making the report to the CEO, send notice to the Participating LIP/HAAP of the final decision. The final decision will be effective immediately and not subject to any other appeal or dispute resolution rights.

## Section 13

### DELEGATED CREDENTIALING

#### Section 13.1 Delegated Credentialing.

- a. Delegated Functions. The Health Plan may delegate the responsibilities for specific credentialing functions to a hospital, group practice, credentials verification organization (CVO) or other entity ("Delegate"). The Health Plan retains the right to ultimately approve LIPs and HAAPs and to terminate or suspend LIPs and HAAPs.
- b. Delegation Agreement. A delegation agreement must describe the responsibilities of the Health Plan and the Delegate, the specific delegated activities, the process by which the Health Plan will evaluate the Delegate's performance, the Health Plan's oversight responsibilities, including the review of reports submitted by Delegate on at least a quarterly basis, the Health Plan's right to approve the Delegate's credentialing decisions, the Health Plan's right to approve and deny participation for quality reasons and the action to be taken if the Delegate does not fulfill its obligations. If applicable, the agreement must include sub-delegation arrangements. Any sub-delegation arrangements must be approved by the Health Plan prior to sub-delegation.
- c. Committee Action. The date the Delegate's Committee recommends action shall be the date the Applicant is considered eligible to participate as a LIP/HAAP of the Health Plan's network and shall also serve as the date for determining the timeliness of all requirements for credentialing and re-credentialing as set forth in the Health Plan and Delegate Agreement. At least quarterly, the Credentialing and Peer Review Committee must review a list of the LIPs, Hospitals and/or Ancillary Providers the Delegate has recommended for acceptance or has accepted with or without restrictions or for termination. The Credentialing and Peer Review Committee may base its recommendations or actions on factors it deems appropriate, whether or not these factors are mentioned in this Credentialing Plan. In reviewing a recommendation or action from the Delegate, the Credentialing and Peer Review Committee may request further information from the Delegate. The Credentialing and Peer Review Committee may table a recommendation pending the outcome of an investigation of the Applicant by a hospital, licensing board, government agency or any other organization or institution; or may take any other action it deems appropriate. Actions of the Credentialing and Peer Review Committee are forwarded to the Quality Committee for notification. Any acceptance of the Delegate's recommendations or actions is conditioned upon the Applicant's agreement to accept the Health Plan's terms and conditions of participation, if applicable.



At any time, the Credentialing and Peer Review Committee in its sole discretion may identify and recommend education or other support, suspension, restriction or termination of a Participating LIP as set forth in Sections 8, 9, 10, 11, and 12.

- d. Revocation or Termination of Agreement. Upon revocation or termination of an agreement between the Health Plan and the Delegate, the Health Plan will obtain copies of Delegate's credentialing and re-credentialing files and place the LIPs/HAAPs, in a queue for re-credentialing on or before their latest due date and in accordance with the procedures outlined in Section 4 and Section 8, respectively. If the Health Plan is unable to obtain copies of Delegate's credentialing and re-credentialing files, the Health Plan will complete an initial credentialing process within six (6) months of the de-delegation.

### **Section 13.2 Delegation to an Accredited or Certified Delegate.**

- a. Pre-Assessment and Annual Audits. If Health Plan delegates the responsibilities for specific credentialing functions to a Delegate recognized as certified or accredited as defined by the Health Plan, pre-assessment and annual audit responsibilities are limited as outlined below:
  - 1) A pre-delegation assessment is not required if the Delegate was certified or accredited prior to implementing the delegation arrangement.
  - 2) An annual evaluation of the Delegate is not required.
  - 3) An audit of the Delegate's operating procedures is not required.
  - 4) An audit of the Delegate's files for the credentialing elements, which have been certified or accredited is not required.
  - 5) If the Delegate has sub-delegated to another entity, the Health Plan must verify that the Delegate is performing its own oversight and annual audits.
- b. On-Going Monitoring. On at least a quarterly basis, the Health Plan is responsible for receiving and reviewing reports on LIPs/HAAPs credentialed and re-credentialed by the Delegated Entity as outlined in the Health Plan and Delegate Agreement.

### **Section 13.3 Delegation to a Non-Accredited or Non-Certified Delegate.**

- a. Prior to Delegation. A pre-assessment of the Delegate must be completed prior to delegation to assess the Delegate's ability to meet or exceed the Health Plan's standards. A pre-assessment will be conducted and must include a review of the functions that will be delegated. Criteria may include, but are not limited to the following:
  - 1) Review of the Delegate's Credentialing Policies and Procedures including those related to confidentiality, peer review and appeals;
  - 2) Review of the Delegate's method for collecting and verifying credentials;
  - 3) Review of Delegate's LIP/HAAP files including record keeping and organizational file structure;
  - 4) Review of Delegate's Credentialing and Peer Review Committee minutes;
  - 5) Appropriateness of suspension, restriction and termination actions;
  - 6) Evidence of Delegate's ability to apply selection criteria uniformly and per the Health Plan's credentialing standards and policies.
- b. Annual Oversight Review and On-Going Monitoring. The Health Plan may complete an Annual Oversight Review and monitor the Delegate's performance on an on-going basis to determine whether the delegated activities are being carried out in accordance with the Delegation Agreement

and Health Plan standards. The Oversight Review will be conducted via desktop review or directly on-site. Oversight reviews will include policy review and randomly requested credentialing and re-credentialing files. The desk top review shall be completed within a specified timeframe as requested. Reports of oversight and monitoring will be reviewed by the Health Plan's Credentialing and Peer Review Committee on at least a quarterly basis.

## **Section 14**

### **MISCELLANEOUS**

**Section 14.1 Deadlines.** The time periods specified in this Plan are intended to provide guidelines for the routine processing of applications, requests for re-credentialing, requests for corrective action, or appeals therefrom. Deviation from the time periods set forth in this Plan shall not constitute grounds for invalidating any actions taken pursuant to this Plan.

**Section 14.2 Provider Directory.** All LIP/HAAPs promoted as an in-network provider will be credentialed pursuant to this Credentialing and Re-Credentialing Plan, prior to being listed in the Provider Directories. LIP/HAAP's ceasing to comply with the credentialing criteria outlined in the Plan, will be removed from the Provider Directories until compliance has been met.

**PHYSICIANS HEALTH PLAN**

**Credentialing Plan**

**2022**

**Physicians Health Plan Credentialing and Peer Review Committee Chairperson**

\_\_\_\_\_  
**Signature**

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**Print Name**

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**Date**

**Physicians Health Plan Quality Committee Chairperson**

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**Signature**

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**Print Name**

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**Date**