

**PPO USA  
CREDENTIALING AND RECREDENTIALING  
POLICIES AND PROCEDURES**

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## **PURPOSE**

The Policies and Procedures described in this document present a fair and reasonable process to evaluate Credentialing Applications for acceptance into, and for continuing participation in, PPO USA Network (the "Network"), a non-risk bearing PPO network owned and operated by Government Employees Health Association, Inc. ("GEHA"). The Network conducts credentialing and recredentialing activities under contract with and on behalf of PPOs and other payors who provide health care services to their members or enrollees. The following criteria and standards are modeled on those set forth by URAC.

These Policies and Procedure will be reviewed and approved by the Peer Review Committee and the Medical Director annually.

## **POLICY**

The Network documents the mechanism for the credentialing and recredentialing of all Providers and presents them for approval before the Peer Review Committee before execution or renewal of a Provider or Delegated Agreement by the Network.

## **PROCEDURES**

### **I. Scope**

The Network complies with URAC standards for all credentialing and recredentialing functions. Under this program, the Network will credential and recredential all Providers that are providing health care services and that the Network lists or intends to list in the Network's provider directory or website. In addition, the Network may delegate credentialing and recredentialing activities for other contracted provider types or Providers as necessary. This delegation may include, but is not limited to, MDs, Dos, DPs, chiropractors, non-physicians including; nurse practitioners, physician assistants, nutritionists, Alternative Medicine Providers; massage therapists, acupuncturists, mental health providers; physiologists, certified addiction specialists., acute in-patient facilities such as hospitals, and other types of facilities including Home Health, Skilled Nursing Facilities, Birthing Centers and Surgery Centers.

### **II. Definitions**

- A. Ad-Hoc Provider: Specialty expertise to be a standing committee member to participate as a clinical peer on a Dispute Resolution Committee or Appeal Reconsideration Committee panel.
- B. Appeal Reconsideration Committee: The Appeal Reconsideration Committee is comprised of a group of individuals that impartially reviews appeals of adverse decisions of the Dispute Resolution Committee in

accordance with the procedures set forth in Article XIX below. The committee shall consist of at least three qualified individuals, of which at least two may be Peer Review Committee members not involved in the initial adverse action(s) or adverse Dispute Resolution Committee decision, and one who is a Participating Provider who 1) is not a member of the Peer Review Committee; 2) has no other role in management of the Network; and 3) is a clinical peer of the Participating Provider who filed the dispute. This committee may not consist of any individual who was involved with the Dispute Resolution Committee's decision. The Appeal Reconsideration Committee handles all appeal reconsiderations and makes the final decisions regarding adverse actions related to a Participating Provider's status within the Network and a Participating Provider's or Facilities professional competency or conduct.

- C. Clean Application: A clean application is one that does not require Peer Review Committee review because (1) there are no issues that would require review by the Peer Review Committee, (2) the File meets the minimum URAC credentialing standards identified in the Credentialing Process or Recredentialing Process, and (3) the File meets any additional criteria determined by the Network.
- D. Completed Credentialing Application: An application that contains all credentials data and verification of the credentials data has been completed, which may be completed by CVO Vendor.
- E. Conflict of Interest: A conflict of interest may exist for a committee member whenever the outcome of a committee's deliberations could result in personal economic, or other advantage or disadvantage to a committee member personally, or to a committee member's immediate family, or to the Provider or group with which a committee member practices.
- F. Credentialing Application or Recredentialing Application: Forms that request general information from a Health Professional or Health Facility applying for initial credentialing or recredentialing with Network. A Credentialing Application or Completed Credentialing Application or Recredentialing Application will contain the following:
  - 1. A signed and dated application with authorization and release of liability statement.
  - 2. Verification from application view of any of the following that apply to Provider:

- a. clinical privileges in good standing at a hospital designated by the Provider as the primary admitting facility, if applicable
  - b. five-year work history
  - c. medical school with year graduated
  - d. current Medicaid/Medicare status and review for previous sanction activity
3. Verification from primary/or secondary sources of any of the following that apply to Provider:
- a. current, valid license to practice medicine or to practice within scope of education, depending where the Provider intends to provide care, including a request for information regarding prior disciplinary or licensure activity
  - b. valid DEA certificate, as appropriate
  - c. proof of latest schooling completed/Board certification if applicable
  - d. current, professional liability insurance as required by GEHA and state law
  - e. professional liability claims history including denial or cancellation of previous policy
4. A statement from the Provider or Facility should be included if any of the following professional health statuses apply to Provider or Facility:
- a. suspension or limitation of hospital privileges
  - b. suspension as a Medicare or Medicaid provider
  - c. professional liability insurance denied, canceled or not renewed for professional conduct
  - d. state licensing investigation or action
  - e. revoked, expired or suspended license
  - f. DEA licensing investigation or action

- g. conviction of a felony
    - h. chronic illness, physical defects or substance abuse that would impair the ability to practice
  - 5. National Practitioner Data Bank query report
  - 6. Healthcare Integrity and Protection Data Bank query report
  - 7. Ongoing monitoring of sanctions
  - 8. Recommendation from a Credentialing Supervisor and/or Chairperson/Co-Chair concerning Provider's or Facility's acceptance into the Network.
- G. Credentialing Criteria: Defined criteria set forth in the PPO USA Initial Credentialing Criteria for Non-Participating Providers and the PPO USA Recredentialing Criteria for Participating Providers that are reviewed during the Credentialing Process or Recredentialing Process by the Network Representative.
- H. Credentialing Department: The credentialing department of GEHA.
- I. Credentialing Process: Process by which Credentialing Criteria for Non-Participating Provider are verified for use in determining the initial approval for Network participation.
- J. Credentialing Program: The program described in these Policies and Procedures, including the Credentialing Process and Recredentialing Process.
- K. Credentialing Supervisor: An individual appointed by GEHA as the Credentialing Supervisor who has a Certified Provider Credentialing Specialist Certification, or his/her designee. The Credentialing Supervisor has the authority to submit any Participating Provider's adverse or potentially adverse credentialing information to the Peer Review Committee for review at any time.
- L. Delegated Agreement: Health System, PHO, IPA, Group, Hospital or Facility Agreement: A contract between the Network and Health Facility whereby the Health Facility(S) or Health Professional(s) agrees to provide certain health care services and abide by the Network's policies and procedures. A completed Delegated Agreement will contain the following.

1. Original signature of the person that can legally sign on behalf the Health Facility(s) or Health Professional(s) indicating agreement of terms and conditions.
  2. Attached fee schedule and or rate schedule with no revisions noted.
- M. Delegated Credentialing: A transfer of authority and responsibility that occurs when the Network contracts with a party to perform credentialing functions as outlined in the Health System, PHO, IPA, Group, Hospital or Facility agreement. (The party can be a CVO.) The Delegated Credentialing functions must meet or exceed GEHA Credentialing Criteria, Policies and Procedures and URAC standards.
- N. Credentials Verification Organization Vendor or CVO Vendor: A company that is fully accredited by URAC as a Credentials Verification Organization and that facilitates the transmittal of credentials data from the primary source of the credentialing information to GEHA.
- O. Dispute Resolution Committee: The Dispute Resolution Committee has the responsibilities set forth in Section B of Article XIX. The committee is comprised of a group of individuals that impartially reviews any dispute concerning Peer Review Committee or Medical Director's decisions that relate to a Participating Provider's status within the Network and that relate to a Participating Provider's professional competency or conduct. This committee shall consist of three qualified individuals, of which two may be Peer Review Committee members not involved in the adverse action being appealed and one shall be a Participating Provider who (1) is not a member of the Peer Review Committee; (2) has no other role in management of the Network; and (3) is of the same or similar specialty of the Participating Provider who has requested a dispute resolution appeal in accordance with the procedures set forth in Article XIX.
- P. Facility: Any Health Facility that has applied for membership into the Network or is a member in the Network.
- Q. File: The compilation of information about a Provider or Facility that includes all credentialing information, the Provider Delegated Agreement, and all quality of care or service issues.
- R. Health Facility: A facility that: (1) provides covered health care services; and (2) holds a state license if eligible for a state license; and (3) is in good standing status to participate in Medicare, Medicaid, and other Federal health care programs. The foregoing shall include, but not be limited to, acute inpatient Facilities, free-standing surgical centers, birthing centers, home health agencies, and skilled nursing facilities.

- S. Health Professional: An individual who: (1) has undergone formal training in a healthcare field; (2) holds an Associates or higher degree in a healthcare field, or holds a state license or state certificate in a healthcare field; and (3) has professional experience in providing direct patient care. The foregoing shall include, but not be limited to, any physician, MD, DO, DPM, Ph.D., Clinical Psychologists, OD, PT, OT, ST, PA and NP.
- T. Medical Director: A doctor of medicine or doctor of osteopathic medicine who is duly licensed to practice medicine and who is an employee of, or party to a contract with, GEHA, and who has the overall oversight and responsibility for clinical oversight of the organization's utilization management, credentialing, quality management, and other clinical functions. The Medical Director has been delegated authority, by the Peer Review Committee, for approving Clean Applications and a delegated entity's policies and procedures. The Medical Director is also responsible for reviewing quality assurance issues regarding any Provider or Facility who is engaged in behavior or is practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of consumers and has authority to terminate Participating Providers and Health Facilities for any of the reasons set forth in section XVIII below.
- U. Network: PPO USA Network, a non-risk bearing network owned and operated by GEHA.
- V. Network Representative: Medical Director, any member of the Peer Review Committee; Chairperson or his/her designee; a Co-Chair or his/her designee; the Credentialing Supervisor or his/her designee; any employee or staff member of the Network; a Board member of GEHA; a CVO Vendor; and any individual appointed by or authorized by any of the foregoing to perform specific functions related to gathering, analysis, use or dissemination of information.
- W. Non-Participating Provider: A Provider or Facility who has not been credentialed by the Network or that entered into a Provider Delegated Agreement with the Network to provide health care services.
- X. Participating Provider: A Health Professional or Health Facility who has been credentialed by the Network and has entered into a Provider or Facility Agreement with the Network to provide health care services.
- Y. Peer Review Committee: The Peer Review Committee is a group that meets as often as necessary, but no less than monthly: (1) includes one Participating Provider who has no other role in organization management; (2) discusses whether providers are meeting reasonable standards of care; (3) accesses appropriate clinical peer input when discussing standards of

care for a particular type of provider; (4) has final authority to approve or disapprove Credentialing Applications and Recredentialing Applications by Providers, Facilities, or Delegated Credentialing participation status, and has final authority to delegate such authority to the Medical Director for approving Clean Applications; (5) maintains minutes of all Peer Review Committee meetings and documents all actions; (6) provides guidance to Network staff on the overall direction of the Credentialing Program; (7) evaluates and reports to Network management annually on the effectiveness of the Credentialing Program; (8) reviews and approves Policies and Procedures; and (9) may review immediate terminations and make decisions regarding the status of Participating Providers in the Network. The Peer Review Committee must consist of at least three Health Professionals, one of whom should be the Committee Chairperson, the Co-Chair, or their designee, and such others as authorized herein. Additional responsibilities include providing suggestions and/or guidance to the Network regarding clinical and provider payment policies, member access to care, dispute resolution policies, and other Network management processes and policies. In addition, the Peer Review Committee may be asked to review quality assurance issues from the Network as part of its ongoing quality oversight mechanism. Each member of the Peer Review Committee is required to be doctor of medicine, doctor of osteopathic medicine, doctor of podiatric medicine or another specialty that is represented in the Network. The member must be duly licensed to practice in at least one state in the United States, an employee of or a party to a contract with Network, and have post-graduate experience in direct patient care. The Peer Review Committee shall include at least one of the most common types of provider in the Network.

- Z. Peer Review Committee Chairperson and Co-Chair ("Chairperson" and "Co-Chair," respectively): The Chairperson and Co-Chair serve as the Network's clinical decision-makers and have the responsibility for and oversee the day-to-day operations of the Credentialing Department and Credentialing Program, including the Network's quality assurance issues and Credentialing Process and Recredentialing Process. Each Chairperson must be a doctor of medicine, doctor of osteopathic medicine, doctor of podiatric medicine or another specialty who is duly licensed to practice in at least one state in the United States, who is an employee of or a party to a contract with Network, and has post-graduate experience in direct patient care. Either the Chairperson or the Co-Chair must be Board certified and one of them must be a Participating Provider who has no other role in the organization's management.
  
- AA. Policies and Procedures: Policies and Procedures are those policies and procedures as set forth herein as may be amended from time to time.

- BB. Primary Source Verification: Verification by the Network of a Health Professional's or Health Facility's qualifications and credentials based upon evidence obtained by direct contact with the issuing source. Primary source verification may include state licensing board, school/residency/training program, Board certification via ABMS master file, AMA master file, AOA master file, the Education Commission for Foreign Graduates, or Special Board of Registry.
- CC. Provider: Any Participating or Non-Participating Provider.
- DD. Provider Agreement: A contract between the Network and a Health Professional whereby the Health Professional agrees to provide certain health care services and abide by the Network's policies and procedures. A completed Provider Agreement will contain the following:
1. Original signature of the Provider indicating agreement of terms and conditions.
  2. Attached fee schedule and or rate with no revisions noted.
- EE. Provider Relations Department of the Network or Provider Relations Department: The department of the Network that executes and maintains Provider and/or Delegated Agreements and handles various Provider and Facility issues.
- FF. Recredentialing Process: A process of review to assess and update the qualifications and credentials of a Health Professional or Health Facility for ongoing Network participation as set forth in Section VII below.
- GG. Secondary Verification: Verification by the Network of a Health Professional's or Health Facility's qualifications and credentials based upon evidence obtained by legitimate means other than direct contact with the issuing source or the credential (e.g., copies of required documentation).

### **III. Credentialing Application Process**

The provisions of this Article III shall govern the application process for Health Professional(s).

- A. Submitted Application must include the following:
1. History of education and professional training, including Board certification status if applicable;

2. State licensure information, including current license(s), history of licensure in all jurisdictions, and history of licensure investigations/encumbrances;
  3. Evidence of current Drug Enforcement Agency (DEA) certification or state controlled dangerous substance certificate, if applicable, and history of investigations/encumbrances;
  4. Proof of liability insurance;
  5. Professional liability claims history and history of malpractice information;
  6. History of sanctions;
  7. History of loss or limitation of privileges or disciplinary activity;
  8. History of hospital affiliations or privileges, if applicable;
  9. Disclosure of any physical, mental, or substance abuse problems that could, without reasonable accommodation, impede the Provider's ability to provide care according to accepted standards of professional performance or pose a threat to the health or safety of patients;
  10. A signed and dated statement attesting that the information submitted with the application is complete and accurate to the Provider's knowledge;
- B. If the applicant does not submit at least the minimum information outlined above, the Network Representative or the CVO Vendor shall inform the applicant of the Network's requirements and the Provider will not be included in the Credentialing Process.

#### **IV. Initial Credentialing Process for Providers**

The provisions of this Article IV shall govern the Credentialing Process for Non-Participating Providers.

- A. Credentialing Application File
1. By signing, dating, and submitting a Credentialing Application, the Non-Participating Provider:
    - a. Acknowledges and attests that the Credentialing Application is correct and complete and acknowledges that

any significant misstatement or omission is grounds for a denial of membership or for termination from the Network.

- b. Consents to the release and review by Network Representatives of all documents for the purpose of credentialing and recredentialing (including requesting and reviewing information from the National Practitioner Data Bank and any other data bank the Network is permitted or required by law to access) that may be necessary to evaluate his or her professional qualifications and ability to meet the qualifications to participate in the Network, initially and on an ongoing basis, as well as his or her professional ethical qualifications for Network membership, and consents to Network Representatives consulting with prior associates or others who may have information bearing on his or her professional or ethical qualifications and competence.
- c. Understands and agrees that if membership is denied based on the Non-Participating Provider's professional competence or conduct, the Non-Participating Provider may be subject to reporting to the National Practitioner Data Bank.
- d. Releases from any liability all Network Representatives and/or the GEHA Board of Directors for their acts performed in good faith and without malice in connection with reviewing, evaluating or acting on the Credentialing Application and the Non-Participating Provider's credentials.
- e. Releases from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to Network Representatives and/or the GEHA Board of Directors in good faith and without malice concerning the Non-Participating Provider's ability, professional ethics, character, physical and mental health, emotional stability, and other qualifications necessary for appointment as discussed herein.
- f. Agrees that any lawsuit brought by Non-Participating Provider against an individual or organization providing information to a Network Representative and/or the GEHA Board of Directors or against the Network or Network

Representatives or the GEHA Board of Directors, shall be brought in a court, federal or state, in the state in which the defendant resides or is located.

- g. Agrees to practice in an ethical manner and to provide continuous care to patients.
  - h. Agrees to notify the Network immediately if any information contained in the Credentialing Application changes. The foregoing obligation shall be a continuing obligation of the Provider so long as he or she is a member of the Network.
  - i. Agrees to be bound by the terms of and to comply with all respects of these Policies and Procedures.
2. Once the signed and dated Credentialing Application with release of liability and the supporting documents are received from the Non-Participating Provider the following information will be verified:
- a. History of education and professional training, including Board certification status, if applicable; **Primary** source verification must include a state licensing Board, school/residency/training program, Board certification via ABMS master file, AMA master file, AOA master file, the Education Commission for Foreign Graduates, or a National Clearing House.
  - b. State licensure information, including current license(s) and history of licensure in all jurisdictions; **Primary** source verifications via state licensing Board must include the expiration date of the license, the date it was verified, and whether there are any sanctions on the license. The license must be current and valid when presenting to the Peer Review Committee.
  - c. Evidence of current Drug Enforcement Agency (DEA) certification or state controlled dangerous substance certificate, if applicable; **Primary** source verification via National Technical Information Services (NTIS) or secondary source verification via copy.
  - d. Proof of liability insurance; **Secondary** source verification of the liability insurance cover sheet. The cover sheet must

include the name of the Non-Participating Provider, the expiration date and the liability covered. If the cover sheet does not include the name of the Non-Participating Provider, then a photocopy of those covered under the plan must be submitted on a sheet that includes the insurer's letterhead. The cover sheet must be current and valid when presented to the Peer Review Committee.

- e. Professional liability claims history; Credentialing Application requires disclosure of claims history for all cases that are settled or have resulted in an adverse judgment against the Non-Participating Provider.
- f. History of sanctions; Credentialing Application requires disclosure of sanction history from state licensing Boards as well as Medicare/Medicaid. Office of Inspector General (OIG) is used to verify Medicare/Medicaid sanctions.
- g. History of loss or limitation of privileges or disciplinary activity; Credentialing Application requires disclosure of loss or limitation of privileges or disciplinary actions.
- h. Hospital affiliations or privileges, if applicable; Credentialing Application requires 5 years privilege history, if the Non-Participating Provider has been in practice that long.
- i. Disclosure of any physical, mental, or substance abuse problems that could, without reasonable accommodation, impede the Non-Participating Provider's ability to provide care according to accepted standards of professional performance or pose a threat to the health or safety of patients; Credentialing Application requires disclosure of any threat to the health or safety of patients.
- j. A signed and dated attestation that the information submitted with the Credentialing Application is complete and accurate to the Non-Participating Provider's knowledge. An electronic signature is acceptable to meet this requirement.

## V. Credentialing Process for Facilities

### The provisions of this Article V 1. and 2. shall govern the Credentialing Process for Facilities.

1. Once the signed and dated Application with release of liability and the supporting documents are received from the Facility, the following information will be verified:
  - a. State licensure information, if facility is eligible for a state licensure, including current license(s) and history of licensure in all jurisdictions; **Secondary** source verifications via copy must include the expiration date of the license, the date it was verified, and whether there are any sanctions on the license. The license must be current and valid when presenting to the Peer Review Committee.
  - b. Proof of liability insurance; **Secondary** source verification of the liability insurance cover sheet via copy. The cover sheet must be current and valid when presented to the Peer Review Committee.
  - c. Professional liability claims history; **Application** requires disclosure of claims history for all cases that are settled or have resulted in an adverse judgment against the facility.
  - d. History of sanctions; **Application** requires disclosure of sanction history from state licensing Boards as well as Medicare/Medicaid. Medicare/Medicaid status verified via Office of Inspector General (OIG).
  - e. Accreditation status; **Secondary** source verification of accreditation status via copy of certificate.
  - f. A signed and dated statement from an authorized representative of the facility attesting that the information submitted with the application is complete and accurate to the representative's knowledge.
  - g. A signed and dated statement from an authorized representative authorizing GEHA to collect any information necessary to verify the information in the credentialing application.

2. Once the Application, that includes the release of liability and the supporting documents, are received from the Facility, and the Network Representative queries the Healthcare Integrity and Protection Data Bank, the following will occur:
  - a. The Credentialing Supervisor or his/her designee will review the Completed Credentialing Application File and document any deviation from the Credentialing Criteria.
  - b. Prior to the scheduled Peer Review Meeting, a Committee Chairperson or Co-Chair reviews the Completed Credentialing Application File(s) that deviate from the Credentialing Criteria and makes recommendations for the Peer Review Committee.
  - c. If the Facility Credentialing Application is denied by the Peer Review Committee, the Credentialing Supervisor or designee shall send a letter by signature confirmation mail, of the decision to the Facility and a copy of the letter is placed in the Facility's File.
  - d. If a Facility is denied acceptance into the Network for reasons based on the representative's of the Facility's professional competence or professional conduct, the Facility shall be entitled to notice and appeal process as set forth in Article XIX, as applicable.
  - e. If the Credentialing Process is deferred by the Peer Review Committee, the Credentialing Supervisor or his/her designee shall again request information from the Facility by means of telephone or by written request.
    - i. If requested information is received within the timeframes and manner specified as listed in Article VI. 9, the Provider or Facility submitted information will be presented at a Peer Review meeting.

## **VI. Decision on Network Participation**

1. No Non-Participating Provider shall be denied membership on the basis of race, color, creed, ancestry, sex, sexual orientation, age, religion, marital status, national origin, physical, mental or sensory disability, or health status unrelated to the ability to fulfill patient care.

2. The Non-Participating Provider is responsible for providing a Completed Credentialing Application and for producing information adequate to properly evaluate his or her ability to meet the qualifications to participate in the Network, including, but not limited to, experience, background, training, demonstrated competence, utilization patterns, work habits, and other history, to resolve any doubts or conflict, and to clarify information as requested by Network Representatives, including but not limited to the Credentialing Supervisor, Chairperson, a Co-Chair, or a Peer Review Committee Member.
3. A Credentialing Application may be automatically denied for any of the reasons set forth in Article XVIII.B. This action shall be final except when a bona fide dispute exists as to whether the circumstances have occurred. No Non-Participating Provider shall be entitled to the procedural rights set forth in Article XIX, as the result of an automatic denial imposed pursuant to this section. If the Credentialing Application is automatically denied, a Network Representative shall send a signature confirmation letter of the decision to the Non-Participating Provider and a copy of the letter will be placed in the File.
4. The Non-Participating Provider's Files that include incomplete Credentialing Applications or insufficient information to meet the minimum credentialing requirements are not submitted to the Peer Review Committee. A letter will be mailed to the Non-Participating Provider as expeditiously as possible, but in no event later than 90 days following the date of receipt of the Application, informing him or her that the Application is incomplete, unless a shorter timeframe is required by law. The Credentialing Process will be deferred until such time that the information is provided to the Credentialing Department.
5. When a Completed Credentialing Application is presented to the Peer Review Committee, the Chairperson or Co-Chair will remind committee members to consider Conflict of Interest issues. If a Conflict of Interest exists for any committee member, the member shall not participate in deliberation and/or voting on any matter related to the File. If there are any questions concerning whether a Conflict of Interest exists, members should address questions to the Chairperson before any activity on the File. Whenever a conflict exists, the minutes of the relevant meeting will reflect the disclosure of the fact of a member's conflict and that the member did not participate in deliberation or voting on the matter.

6. The meetings of the Peer Review Committee and the Files will be considered confidential. The Chairperson or Co-Chair will remind the Peer Review Committee prior to each committee meeting of the necessity of confidentiality. The File shall not be subject to discovery, subpoena or other means of legal compulsion of their release.
7. The Peer Review Committee will review the Credentialing Application and accept, deny, or defer for further consideration the Non-Participating Provider's acceptance into the Network within 90 days of receipt of the completed Credentialing Application, unless a shorter timeframe is required by law, in which case the Network will comply with applicable law.
8. Criteria for Denial of a Credentialing Application: The Peer Review Committee may deny a Credentialing Application for any reason set forth in these Policies and Procedures and the PPO USA Initial Credentialing Criteria, as amended from time to time, and such reasons include, but are not limited to, the following:
  - a. The Non-Participating Provider education is unsatisfactory.
  - b. The Network has previously terminated the Non-Participating Provider or denied a Non-Participating Provider for Credentialing or Recredentialing participation in the Network in the previous year.
  - c. The Non-Participating Provider's credentials are unsatisfactory.
9. Criteria for Deferral of a Credentialing Application: The Peer Review Committee may defer a Credentialing Application to request clarification(s) and/or additional information related to the Credentialing Process. A Non-Participating Provider shall have 30 days to submit additional information after such request is sent to the Non-Participating Provider. Such requested information shall be delivered to the Credentialing Supervisor or his/her designee and shall be forwarded to the Peer Review Committee. If the requested information is not provided within the time and in the manner specified, then that Non-Participating Provider Credentialing Process may be deferred.
10. The Chairperson, Co-Chair and the Peer Review Committee will review the credentialing information and make decisions at a

committee meeting and determine if the Non-Participating Provider will be accepted into the Network.

- a. If the Peer Review Committee approves a Non-Participating Provider Credentialing Application, the Credentialing Department will send notification to the Non-Participating Provider of the determination of his/her Credentialing Application within 10 business days of the determination. The Provider Relations Department shall send a copy of the executed Provider or Delegated Agreement and notification of the Non-Participating Provider's participation effective date. The notification will contain the Non-Participating Provider's specialty information for Health Professionals. The original executed contract and a copy of the notice will be placed in the File.
- b. If the Non-Participating Provider Credentialing Application is denied by the Peer Review Committee, the Credentialing Supervisor or designee shall send a signature confirmation letter of the decision to the Non-Participating Provider within 10 business days and a copy of the letter is placed in the Non-Participating Provider File.
- c. If the Credentialing Process is deferred by the Peer Review Committee, the Credentialing Supervisor or his/her designee shall continue to follow up in good faith to request information from the Non-Participating Provider by means of telephone or by written request.
  - i. If the requested information is received within the timeframes and manner specified as listed in Section VI.10, the additional information will be presented at a Peer Review meeting.
  - ii. If the requested information is not received within the timeframes and manner specified as listed in Section VI.10, the Non-Participating Provider's Credentialing Application, absent the requested information, will be reviewed at a Peer Review meeting. At such meeting, the Peer Review Committee may review the Application based on available information or find it to be incomplete.
  - iii. If the Non-Participating Provider's Credentialing Application is found to be incomplete by the Peer

Review Committee after following the procedures in Section VI.11.d.ii., the Credentialing Supervisor or his/her designee shall send a letter to the Non-Participating Provider by signature confirmation mail of the decision to continue to defer the Application and a copy of the letter shall be placed in the File. The Application will continue to be deferred until such time that the required information is received or timeframes are exhausted, as set forth in Article XI.

11. A Non-Participating Provider may withdraw his or her initial Application at any time during the initial Credentialing Process or within 30 days of receipt of the Non-Participating Provider's written notice of initial denial letter. Failure to withdraw an initial Application in the manner and timeframe specified herein will result in the final denial action being reported to the National Practitioner Data Bank ("NPDB").

## **VII. Credentialing Process for Recredentialing and/or Adverse Credentialing Information Received during the Ongoing Monitoring Process of Participating Providers**

The provisions of this Article VII shall govern the Recredentialing and/or Ongoing Monitoring Process for Participating Providers.

- A. Participating Providers shall be recredentialed every three years and evidence of the Recredentialing Process shall be kept with the initial credentialing information in the File. So long as Participating Providers submit all required documentation for the recredentialing process as described in these policies, Participating Providers shall be deemed to be approved in the recredentialing process unless otherwise notified in writing by GEHA.
- B. Recredentialing Process for Participating Providers:
  1. By submitting a signed and dated Recredentialing Application, the Participating Provider acknowledges, consents and agrees to all provisions with respect to the Recredentialing Process.
  2. Recredentialing will require re-verification, if necessary, of all the items listed:
    - a. Current statement from the Participating Provider, if necessary, regarding any revisions, to any of the following,

that occurred since their last Credentialing Process or Recredentialing Process:

- i. Physical and mental health status that may impair the Participating Provider's ability to perform the essential functions of a Health Professional with or without accommodation;
  - ii. Impairment due to chemical dependency/substance abuse;
  - iii. Suspension, revocation, or limitation of hospital privileges, if applicable;
  - iv. Suspension as a Medicare or Medicaid Participating Provider or other Federal or State health care program;
  - v. Professional liability insurance denied, canceled or not renewed due to professional conduct;
  - vi. State licensing investigation or action;
  - vii. Revoked, expired, suspended, or restricted license;
  - viii. DEA licensing investigation or action;
  - ix. Conviction of a felony.
- b. Update of the Participating Provider's work history since last credentialed, if applicable.
  - c. Verification of receipt of the Recredentialing Application and signed authorization from the Participating Provider, including release of liability statement.
  - d. Primary source verification of the following
    - i. Current state license;
    - ii. Board certification(s), if applicable, or highest level of education. (This applies to initial credentialing only, unless the Participating Provider's Board certification is the type that expires, or if there is no record of verification in the Participating Provider's File.)

- iii. DEA certificate;
  - e. Valid copies or secondary source from the Participating Provider of the following;
    - i. Proof of professional liability insurance as required, in a form acceptable by GEHA;
  - f. Network's or CVO's query of the National Practitioner Data Bank to determine if there has been any malpractice cases, licensing investigations/limitations, etc. against the Participating Provider since the last credentialing occurrence.
  - g. Any reports of disciplinary actions published by Office of Inspector General (OIG). The Network will monitor these reports on an ongoing basis.
  - h. Review of the following data concerning the Participating Provider obtained from Provider Relations Department, if applicable, and/or adverse to the Participating Provider:
    - i. Member complaints;
    - ii. Results of quality of care or service reviews;
    - iii. Member satisfaction surveys;
    - iv. Participating Provider File.
- 3. Upon the occurrence of an adverse ongoing monitoring event, the Credentialing Supervisor may submit the information to the next Peer Review Committee Meeting for review and recommendation, the Participating Provider may be recredentialed, and the network may re-verify, if necessary, the items listed:
  - a. Any of the following that occurred since the last Credentialing Process or Recredentialing Process:
    - i. Suspension, revocation, or limitation of hospital privileges, if applicable;
    - ii. Suspension as a Medicare or Medicaid Participating Provider or other Federal or State health care program;

- iii. State licensing investigation or action;
    - iv. Revoked, expired, suspended, or restricted license;
    - v. DEA licensing investigation or action;
    - vi. Conviction of a felony.
  - b. Primary source verification of the following
    - i. Current state license;
    - ii. DEA certificate;
  - c. Network's query of the National Practitioner Data Bank to determine if there has been any malpractice cases, licensing investigations/limitations, etc. against the Participating Provider since the last credentialing occurrence.
  - d. Any reports of disciplinary actions published by Office of Inspector General (OIG). The Network will monitor these reports on an ongoing basis.
  - e. Review of the following data concerning the Participating Provider obtained from Provider Relations Department, if applicable, and/or adverse to the Participating Provider:
    - i. Member complaints;
    - ii. Results of quality of care or service reviews;
    - iii. Member satisfaction surveys;
    - iv. Participating Provider File.
- 4. The above information shall be gathered and reviewed by the Peer Review Committee. The committee shall ensure that the Health Professional license, clinical privileges, if applicable, a valid DEA certificate, current malpractice insurance, and Medicaid/Medicare status are still valid and current for the recredentialing process. In addition, all other information gathered during the Recredentialing Process for recredentialing shall be reviewed to ensure compliance with Network standards.

**C. Recredentialing Process for Participating Facilities**

1. By submitting a signed and dated Recredentialing Application, the Participating Facility acknowledges, consents and agrees to all provisions with respect to the Recredentialing Process.
2. Recredentialing will require re-verification, if necessary, of all the items listed:
  - a. Current statement from the Participating Facility, if necessary, regarding any revisions, to any of the following, that occurred since their last credentialing process:
    - i. State licensing investigation or action;
    - ii. Revoked, expired, suspended, or restricted license;
    - iii. Conviction of a felony;
  - b. Verification of receipt of the Recredentialing Application and dated and signed authorization from the Participating Facility's authorized representative with release of liability statement.
  - c. Verification of the following
    - i. Current state license; if facility type is eligible for state licensure. **Secondary** source verification via copy.
    - ii. Medicare/Medicare certification status; **Primary** source verification via Office of Inspector General (OIG)
    - iii. Proof of professional liability insurance as required, in a form acceptable by PPO USA; **Secondary** source verification via copy.
  - d. Network's query of the Healthcare Integrity & Protection Data Bank to determine if there has been any malpractice cases, licensing investigations/limitations, etc. against the Participating Facility since the last Credentialing occurrence.
  - e. Network will review reports of disciplinary actions published by Office of Inspector General (OIG) and will monitor these reports on an ongoing basis.

- f. Review of the following data concerning the Participating Facility obtained from Provider Relations Department, if applicable and/or adverse to the Facility:
  - i. Member complaints;
  - ii. Results of quality reviews;
  - iii. Member satisfaction surveys;
  - iv. Participating Facility file.
3. The above information shall be gathered and reviewed by the Peer Review Committee. The committee shall ensure that the health facility license, current malpractice insurance, and Medicaid/Medicare status are still valid and current. In addition, all other information gathered during the Recredentialing Process shall be reviewed to ensure compliance with Network standards.

#### **VIII. Decision on Continued Network Participation**

1. No Participating Provider shall be denied membership on the basis of race, color, creed, ancestry, sex, sexual orientation, age, religion, marital status, national origin, physical, mental or sensory disability, or health status unrelated to the ability to fulfill patient care.
2. The Participating Provider is responsible for notifying the Network of any changes to credentialing information and for producing information adequate to properly evaluate the ability to meet the qualifications for continued participation in the Network, including, but not limited to, his/her experience, background, training, demonstrated competence, utilization patterns or work habits, to resolve any doubts or conflicts, and to clarify information as requested.
3. A Participating Provider may be automatically denied for any of the reasons described in Article XVIII.B. This action shall be final except when a bona fide dispute exists as to whether the circumstances have occurred. No Participating Provider shall be entitled to the procedural rights set forth in Article XIX, as the result of an automatic denial imposed pursuant to this section.
4. Criteria for denial of a Recredentialing Application: The Peer Review Committee may deny a Recredentialing Application for

any reason set forth in these Policies and Procedures and the PPO USA Recredentialing Criteria, as amended from time to time. Participating Provider shall be entitled to the procedural rights set forth in Article XIX, as applicable.

5. Criteria for denial due to ongoing monitoring: The Peer Review Committee may deny a Provider for any reason set forth in these Policies and Procedures and the PPO USA Recredentialing Criteria, as amended from time to time. Participating Provider shall be entitled to the procedural rights set forth in Article XIX, as applicable.
6. The procedures set forth in Articles VII and VIII shall apply to the Recredentialing Process and the ongoing monitoring review.

## **IX. Credentialing Confidentiality**

The provisions of this Article IX shall govern the confidentiality process for Health Professional(s) or Health Facilities.

- A. The provision encompasses the Credentialing Process/Recredentialing Process, Network Representative and Peer Review Committee responsibilities, and confidentiality procedures as they apply to both hard copy and electronic credentialing information at GEHA.
  - A. Confidentiality of credentialing information.
    - i. Hard copy Files; will be kept locked at all times
    - ii. Electronic files; access to files limited by password
    - iii. Copies of credentialing information; discarded in locked bin or shredded
  - B. Access to Files
    - i. Limited to authorized personnel only
    - ii. Confidentiality training for authorized personnel
    - iii. Confidentiality statements are signed by authorized personnel

## **X. Review of Credentialing Information**

A. This provision is to review credentialing information for completeness, accuracy and conflicting information.

A. Quality audit process is completed on 100% of completed Files before consideration by the Peer Review Committee.

B. Credentialing information is reviewed for the following information

i. Missing;

ii. Incorrect;

iii. Inconsistent/conflicting;

iv. Timeframes for primary source verification, signature attestation and date;

Files will be audited for quality and the information will be documented, reviewed, and tracked, and completion of the audit will be documented.

## **XI. Credentialing Timeframe**

A. This provision requires GEHA not to submit for review any Credentialing Application or Recredentialing Application that:

1. Is signed and dated more than 180 days prior to the Peer Review Committee review. If the applicant's signature on the attestation page is over 180 days, the Provider or Facility must re-sign the attestation.

2. Contains Primary or Secondary Source Verification information collected more than six months prior to review.

3. Contains evidence of an expired, suspended or revoked license. All license verification must include the expiration date of the license and the date it was verified. The license must be current and valid when presented to the Peer Review Committee.

4. Contains evidence of an expired Board certification or certification. Board certification or certification as being current and valid applies to initial credentialing only, unless the Provider's

or Facility's Board certification or certification is the type that expires.

## **XII. Credentialing Communication Mechanisms**

- A. The Network communicates with Providers or Facilities about their credentialing status upon request by:
- i. Letters;
  - ii. Phone calls;
  - iii. Postcards;
  - iv. Emails; and
  - v. Facsimiles.
- B. Prior to final review, the Network will accept additional information from Providers to correct incomplete, inaccurate, or conflicting credentialing information. Providers or Facilities will be notified of the right to correct information by Network Representatives by:
- i. Phone calls;
  - ii. Emails; and/or
  - iii. Facsimiles.
- C. Incomplete, inaccurate, or conflicting information must be submitted to the Credentialing Department within the 180-day credentialing period. Submissions of corrections by Providers or Facilities must be submitted by:
- i. Letter;
  - ii. Email;
  - iii. Facsimile; or
  - iv. Phone.

Receipt of the correction(s) will be documented by the Network Representative.

- D. Notification to the Provider or Facility of these rights will be provided via one of the following:
  - i. Provider Manual;
  - ii. Website; or
  - iii. Other information distributed.

### **XIII. Credentialing Determination Notification**

- A. Written notification to Providers or Facilities of the determination of the credentialing application shall be sent within the following timeframes:
  - 1. Verification pending files; during initial review and every 30 days thereafter until receipt of missing documents via letter or until required timeframes exhausted.
  - 2. Approval of Credentialing Application or Recredentialing Application; within 10 business days of the determination via postcard.
  - 3. Denial of Credentialing Application or Recredentialing Application; within 10 business days of the determination by letter via signature confirmation mail.

### **XIV. Participating Provider Credentials Monitoring**

- A. The network performs ongoing monitoring of Participating Provider sanctions and complaints between recredentialing cycles in order to ensure the quality of Participating Providers and the safety of members. The ongoing monitoring ensures that issues have been identified, and when appropriate, acted on in a timely manner during the interval between initial and recredentialing cycles.
  - 1. The Network will monitor the Participating Provider's continuing compliance with criteria for Network participation through the use of:
    - i. Office of Inspector General (OIG) Reports, such as the OIG's excluded provider database; and
    - ii. State Licensing Boards.

2. GEHA will review Participating Provider Files in which a Participating Provider ceases to comply with Network criteria through use of the following reporting entities:
  - i. NPDB
  - ii. HIPDB
  - iii. OIG
  - iv. State Licensing Boards
3. Upon the discovery of an adverse credentialing event during the ongoing monitoring process, GEHA may recredential the Participating Provider sooner than the next recredentialing date or review the adverse credentialing information in accordance with Section VII.

#### **XV. Delegation of Credentialing/Recredentialing**

The Network may elect to delegate the Credentialing Process/Recredentialing Process to other health care entities for subsets or for all of the Participating Providers in the Network and Non-Participating Providers. The decision to delegate the process will be made after careful review of the entity's credentialing policies, procedures and records. If the Credentialing Process/Recredentialing Process is delegated the following shall exist:

- A. A contract with the entity that will contain a written description of Credentialing/Recredentialing Process.
- B. A contract with the entity allowing the Network to retain the right to approve new Participating Providers and sites and to terminate or suspend individual Participating Providers.
- C. A plan to periodically review the effectiveness of the delegated entity's Credentialing Process/Recredentialing Process, and to perform site visits of the delegated entity to review its Credentialing Process/Recredentialing Process.

#### **XVI. Credentialing Delegation**

- A. Prior to entering into a delegated credentialing agreement, GEHA evaluates the capability of the delegated entity to perform the credentialing functions according to GEHA requirements and consistent with URAC Standards. The evaluation includes the following:

1. Reviewing the delegated credentialing entities' credentialing criteria, policies, and procedures to ensure they meet or exceed those of GEHA and URAC.
    - i. Medical Director will review delegated credentialing entities that meet GEHA requirements or URAC standards.
    - ii. Peer Review Committee will review delegated credentialing entities that do not meet GEHA requirements or URAC standards.
  2. Ensuring GEHA retains authority to make the final credentialing determination regarding any Provider or Facility.
  3. Performing an initial onsite review of a new contracted delegated entity within the first year after their effective date.
  4. Conducting, at least every three years, onsite surveys of each entity that performs credentialing functions on behalf of GEHA.
  5. Maintaining an oversight mechanism to ensure that the delegated entity functions are within the scope of URAC accreditation standards and GEHA requirements.
- B. Onsite visits will include review of a random sample of completed Provider or Facility Files, credentialing criteria, policies, and procedures.
1. Sample size will be 10 percent of the files, but in no case less than 10 files or more than 30 files.
  2. The Network will institute actions to improve delegated entity's audit results that have deficiencies or do not meet thresholds.
  3. The Network will document follow-up for delegated entities that have deficiencies or do not meet thresholds
- C. Periodic review will be conducted. The review will include the following.
1. Periodic review (no less than annually) of the delegated entity's written policies and procedures and documentation of quality assurance activities for related delegated functions.
  2. Verification of compliance with contractual requirements and written policies and procedures.

3. Monitoring financial incentives to ensure the quality of care or services is not compromised, if applicable.

## **XVII. GEHA Consumer Safety Credentialing Investigation**

- A. GEHA performs expedited review and investigation of any issue related to potential adverse quality of care or services provided to consumers with respect to a Participating Provider. The review and investigation could be initiated based on:
  1. Complaints (member or provider);
  2. Network status issues;
  3. Professional competency or conduct issues;
  4. Quality of care or service issues;
  5. Occurrences discovered during the Recredentialing Process; and/or
  6. Other issues identified through the quality assurance process.
- B. The review and investigation includes:
  1. NPDB query;
  2. OIG status review;
  3. License review;
  4. Previous credentialing occurrence reviews; and/or
  5. Previous quality of care or service reviews
- C. Upon initiation of an investigation, Network management shall meet to determine whether the issue is a potential significant risk to consumer health, safety or welfare and, if so, the issue shall be reviewed by the Medical Director. If appropriate, the Participating Provider shall be summarily suspended in accordance with Section C of Article XVIII.

## **XVIII. Termination and Suspension Process**

- A. **Voluntary Termination.** A Participating Provider's participation in the Network shall be considered voluntarily terminated by the Participating Provider as described herein as of the date of the occurrence of any of the events described herein or the date GEHA discovers the event, whichever

is later, and Participating Provider's Provider Agreement shall automatically terminate. This action shall be final and no Participating Provider shall be entitled to the procedural rights set forth in Article XIX below as the result of a voluntary termination by the Participating Provider.

1. The Participating Provider fails/refuses to submit all required recredentialing information within the 180-day Recredentialing Process deadline, as required by the Recredentialing Criteria and as reported to the Network by the Credentialing Department.
2. The Participating Provider retires.
3. The Participating Provider dies.
4. The Provider moves to a state in which the network does not operate. Network is unable to locate the Participating Provider following a good faith attempt.
5. The Participating Provider voluntarily terminates his or her Provider Agreement.
6. The Provider Agreement is terminated at the end of an initial or renewal term.

B. Automatic Termination. A Participating Provider's participation in the Network shall be automatically terminated as described herein as of the date of the occurrence of the event described herein or the date GEHA discovers the event, whichever is later. This action shall be final except when a bona fide dispute exists as to whether the circumstances have occurred. No Participating Provider shall be entitled to the procedural rights set forth in Article XIX, as the result of an automatic termination imposed pursuant to this section.

1. Occurrences Affecting Licensure: The Participating Provider's license to practice in any state in which the Participating Provider is or will be providing services pursuant to a Provider Agreement is revoked, limited or restricted, suspended, or expired.
2. Occurrences Affecting Controlled Substances Regulation: The Participating Provider's DEA or other controlled substances number in any state in which the Participating Provider is or will be providing services pursuant to a Provider Agreement is revoked, suspended, restricted, or expired.

3. Conviction of a Crime: The Participating Provider has been finally adjudicated and found guilty, or entered a plea of guilty or nolo contendere, in a criminal prosecution under the laws of any state or of the United States, for any felony or any offense reasonably related to the qualifications, functions or duties of the medical or health profession, for any offense an essential element of which is fraud, dishonesty or an act of violence.
  4. Exclusion from State or Federal Health Care Reimbursement Programs: The Participating Provider has been excluded, debarred, suspended or otherwise prohibited from participation in any state or federal health care reimbursement program including Medicare, Medicaid, TRICARE, the Federal Employees Health Benefits Program, or any other state or federal health care reimbursement program.
  5. Professional Liability Insurance: The Participating Provider fails to have, carry or maintain professional liability insurance as required by GEHA.
- C. Summary Suspension. If, in the opinion of the Medical Director, Chairperson or Co-Chair, a Participating Provider is engaged in behavior or is or may be practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of consumers, the Medical Director may suspend, pending investigation, a Participating Provider's participation in the Network. Such investigation shall be conducted by the Network's internal department(s) or designee. Notification will be given to the Participating Provider by signature confirmation mail. Summary suspensions shall be effective on the date of the decision. Due to the nature of summary suspensions, the investigation and notification processes will be handled on an expedited basis, including promptly notifying Participating Provider of the summary suspension.
- D. 1. Immediate Termination. The Medical Director, Chairperson or Co-Chair may decide to terminate a Participating Provider's participation in the Network for any reason set forth in this Article XVIII or Policies and Procedures. Such reasons shall include, but not be limited to, the following:
- a. Any finding that a Participating Provider committed professional misconduct or caused a patient harm; and

- b. Membership in the GEHA PPO USA Network and/or privileges granted to Participating Provider are terminated, revoked, restricted, suspended, discontinued or not renewed pursuant to GEHA Credentialing and Recredentialing Policies and Procedures.
- 2. Immediate Termination related to Administrative Matters. The Medical Director, Chairperson or Co-Chair may decide to terminate a Participating Provider's participation in the Network for the following immediate termination reasons related to administrative matters, which are reviewed by GEHA's legal and/or compliance department personnel in order to make a recommendation to the Medical Director, Chairperson or Co-Chair:
  - a. Any falsification of any information on the Participating Provider's Credentialing Application or Recredentialing Application or fraud committed on any documentation; and
  - b. Any finding of unlawful or unprofessional conduct, as defined by state or federal law(s).

Notification will be given to the Participating Provider by signature confirmation mail.

- E. Summary suspensions and immediate terminations shall be final and binding upon the Participating Provider unless the Participating Provider files a written notice of appeal pursuant to the procedures set forth in Article XIX below.
- F. When two or more Participating Provider termination events occur simultaneous, the Participating Provider will be terminated from the Network on the earliest date of any events.
- G. If a Participating Provider is placed in summary suspension status by the Medical Director and a termination event for that Participating Provider occurs during that summary suspension period, the summary suspension status will end on the date immediately prior to the date of the termination event and no further review or appeals will be considered for the summary suspension.
- H. No Participating Provider may appeal an immediate termination if the basis of the immediate termination is based on the same facts or circumstances involved in a summary suspension for the same

Participating Provider and such Participating Provider has already exhausted his or her appeals through the Dispute Resolution and/or Appeal Reconsideration Committees.

## **XIX. Appeal Process**

A. Any dispute concerning an adverse action, as defined below, that relates to a Participating Provider's status with the Network or that relates to a Participating Provider's professional competency or conduct shall be resolved by the procedures set forth in this Article XIX and shall be the sole and exclusive method to resolve such disputes. The Participating Provider shall be bound by any final decision rendered in accordance with said procedures.

1. Adverse Action. The following decisions or actions shall be deemed to be an adverse action or decision and shall entitle the Participating Provider, thereby affected, to the appeal process set forth in this Article XIX.

a. Summary suspension of a Participating Provider's participation in the Network;

b. Immediate termination of a Participating Provider's participation in the Network if not related to administrative matters;

c. Any adverse action relating to a Participating Provider's professional competency or conduct.

2. Voluntary termination under Section XVIII.A or automatic termination under Section XVIII.B shall not be considered an adverse action that entitles the Participating Provider to an appeal.

3. Immediate terminations related to administrative matters under Section XVIII.D.2 shall not be considered an adverse action that entitles the Participating Provider to an appeal under these Policies and Procedures. Immediate terminations related to administrative matters shall have the following appeals process:

If a Participating Provider appeals an immediate termination related to an administrative matter, the appeal must be submitted to the Network within 30 days of the Participating Provider's receipt of his/her/its termination letter from the Network. The Provider Network Manager shall meet with another member of management who was not involved in the initial decision to review the appeal in a fair and impartial manner and, if needed, shall seek advice from legal counsel. The Provider Network Manager shall respond to the Participating Provider's administrative appeal in a timely manner but in no

event later than 90 days following the date of receipt of the administrative appeal from the Participating Provider.

No Participating Provider may appeal an immediate termination if the basis of the immediate termination is based on the same facts or circumstances involved in a summary suspension for the same Participating Provider and such Participating Provider has already exhausted his or her appeals through the Dispute Resolution and/or Reconsideration Committees.

## B. Dispute Resolution Appeal

1. Notice of Adverse Action. A Participating Provider against whom an adverse action or decision has been made shall be given notice of the same within 30 days. The notice shall describe the action and the reason for it. The notice shall also state that the Participating Provider has the right to request an appeal within the time limits specified in Section XIX.B.2 and shall contain a summary of the Participating Provider's rights in such an appeal.
2. Request for Dispute Resolution Appeal. A Participating Provider shall have 30 days after his/her receipt of notice pursuant to Section 1 above to file a written request for an appeal. Such request shall be delivered to a Credentialing Supervisor, or his or her designee, for the Network. A Participating Provider who fails to request an appeal within the time and in the manner specified herein waives any right to such an appeal and to any arbitration to which he/she might otherwise be entitled and the action shall be final upon the expiration of the 30 day period. Such waiver shall constitute acceptance of the adverse action.
3. Informal Meeting. The Dispute Resolution Committee shall have the ability to approve appeal reconsideration in an informal meeting before a scheduled formal appeal is heard.
4. Time and Place of Dispute Resolution Appeal. The appeal review will take place at a Dispute Resolution Committee meeting. Participating Provider shall be notified of time, place and date of appeal meeting to be held. The meeting may be held telephonically, so long as all parties can hear and communicate with each other.
5. Dispute Resolution Committee. The appeal shall be heard by the Dispute Resolution Committee. The Dispute Resolution Committee shall be required to objectively consider and decide the case with good faith. A Dispute Resolution Committee Chairperson will be appointed prior to the meeting and will preside over the appeal process and determine the order of the appeal procedure. The meetings of the Committee and the Files will be considered

confidential. The Dispute Resolution Committee Chairperson will remind the Dispute Resolution Committee prior to each committee meeting of the necessity of confidentiality. These Files shall not be subject to discovery, subpoena or other means of legal compulsion of their release.

6. Conduct of Dispute Resolution Appeal.

- a. During the Dispute Resolution Committee meeting, the following information will be presented to the Dispute Resolution Committee members for examination:
  - i. Participating Provider's File.
  - ii. Adverse Action exhibits with Medical Director's, Chairperson's, Co-Chair's or Peer Review Committee's rationale for termination or suspension.
  - iii. Participating Provider appeal documentation including but not limited to any relevant evidence from Participating Provider or other applicable sources.
- b. The Dispute Resolution Committee shall review all submitted documentation objectively and decide the case with good faith. In reaching a decision, the Dispute Resolution Committee shall be entitled to consider any pertinent material contained on file with the Network, and all other information that can be considered in connection with the Recredentialing Application for the Recredentialing Process.
- c. A record of the appeal shall be kept with sufficient accuracy such that an informed and valid judgment can be made by any group that may later be called upon to review the record and render a decision in the matter. The Dispute Resolution Committee may select the method to be used for making the record, such as electronic recording unit, detailed transcription, or minutes of the proceedings.
- d. The Dispute Resolution Committee shall be entitled to monitor a Participating Provider for a period of time determined by the Dispute Resolution Committee. During the monitoring period, the Participating Provider's credentials will be reviewed based on the decision made by the committee.
- e. The Dispute Resolution Committee Chairman upon a showing of good cause may grant requests for postponement of the appeal review. The Dispute Resolution Committee may recess the appeal proceedings and

reconvene it without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of a presentation of oral and written evidence, the appeal review shall be concluded.

7. Report of Monitoring Period. If adverse information is received during a Participating Provider's monitoring period or if at the end of a monitoring period, no adverse information was received, a teleconference shall be held with the Dispute Resolution Committee, ensuring that all parties can hear and communicate with each other, and the committee shall determine the basis for any decisions. Within 15 days after the monitoring period review is concluded, a written report of the committee's decisions and findings shall be placed in the Participating Provider's File.
8. Report of Dispute Resolution Appeal. Within 15 days after the dispute resolution appeal review is concluded, the Credentialing Supervisor, or his or her designee, shall make a written report of the Dispute Resolution Committee's findings and decisions in the matter, and such report shall be placed in the Participating Provider's File. The report shall include a statement of the basis for the Dispute Resolution Committee's decision(s).
9. Effect of Result.
  - a. If a decision of the Dispute Resolution Committee is favorable to the Participating Provider, notice shall promptly be sent to the Participating Provider informing him/her/it of action taken. Copy of notice will be kept in the Participating Provider's File.
  - b. If a decision of the Dispute Resolution Committee is favorable to the Participating Provider, such results shall become the final decision of the Dispute Resolution Committee and the matter shall be closed.
  - c. If the decision of the Dispute Resolution Committee continues to be adverse to the Participating Provider, the Dispute Resolution Committee shall cause notice of the decision to be given to the Participating Provider via signature confirmation mail, within 30 days. The notice shall describe the action from the Dispute Resolution Committee and the reason for it. The notice shall also state that the Participating Provider has the right to request an appeal within the time limits specified in Section XIX.C.1 below and shall contain a summary of the Participating Provider's rights in such an appeal. A copy of the notice will be kept in the Participating Provider's File.

#### C. Reconsideration Appeal.

1. Request for Reconsideration Appeal. A Participating Provider shall have 30 days after his/her/it's receipt of notice pursuant to Section B.9(c) above to file a written request for an appeal. Such request shall be delivered to the Credentialing Supervisor, or his or her designee, and shall be forwarded to the Appeal Reconsideration Committee. A Participating Provider who fails to request an appeal within the time and in the manner specified herein waives any right to such an appeal and to any arbitration to which he/she might otherwise be entitled and the action shall be final upon the expiration of the 30 day period. Such waiver shall constitute acceptance of the adverse action.
2. Informal Meeting. The Appeal Reconsideration Committee shall have the ability to approve appeal reconsideration in an informal meeting before scheduled formal appeal is heard.
3. Time and Place of Reconsideration Appeal. The appeal review will take place at an Appeal Reconsideration Committee meeting. Participating Provider shall be notified of time, place and date of the appeal review in accordance with Section C.6 below.
4. Appeal Reconsideration Committee. The appeal shall be heard by the Appeal Reconsideration Committee. The Appeal Reconsideration Committee shall be required to objectively consider and decide the case with good faith. The Appeal Reconsideration Committee Chairperson will preside over the appeal process and determine the order of the appeal procedure. The meetings of the Appeal Reconsideration Committee and the Files will be considered confidential. The Appeal Reconsideration Committee Chairperson will remind the Appeal Reconsideration Committee prior to each committee meeting of the necessity of confidentiality. These Files shall not be subject to discovery, subpoena or other means of legal compulsion of their release.
5. Conduct of Reconsideration Appeal.
  - a. During the Appeal Reconsideration Committee meeting, the following information will be presented to the Appeal Reconsideration Committee members for examination:
    - i. Participating Provider's File.
    - ii. Adverse Action exhibits with Medical Director, Chairperson, Co-Chair or Peer Review Committee's rationale for denial/termination.

- iii. Participating Provider reconsideration and appeal documentation including but not limited to any relevant evidence from Participating Provider or other applicable sources.
  - b. The Appeal Reconsideration Committee shall review all submitted documentation objectively and decide the case with good faith. In reaching a decision, the Appeal Reconsideration Committee shall be entitled to consider any pertinent material contained on file with the Network, and all other information that can be considered, pursuant to these Policies and Procedures.
  - c. A record of the appeal shall be kept with sufficient accuracy such that an informed and valid judgment can be made by any group that may later be called upon to review the record and render a decision in the matter. The Appeal Reconsideration Committee may select the method to be used for making the record, such as electronic recording unit, detailed transcription, or minutes of the proceedings.
  - d. The Appeal Reconsideration Committee shall be entitled to suspend a Participating Provider's termination for a period of time determined by the Appeal Reconsideration Committee. During the suspended termination period, the Participating Provider's credentials will be reviewed based on the decision made by the Appeal Reconsideration Committee.
  - e. The Appeal Reconsideration Committee Chairperson, upon a showing of good cause, may grant requests for postponement of the reconsideration appeal review. The Appeal Reconsideration Committee may recess the reconsideration appeal proceedings and reconvene it without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of a presentation of oral and written evidence, the appeal review shall be concluded.
6. Report of Monitoring Period for Summary Suspensions. If adverse information is received during a Participating Provider's monitoring period or if at the end of a monitoring period, no adverse information was received, a teleconference shall be held with the Appeal Reconsideration Committee, ensuring that all parties can hear and communicate with each other, and the committee shall determine the basis for any decisions. Within 15 days after the monitoring period review is concluded, a written report of the committee's decisions and findings shall be placed in the Participating Provider's File.
7. Report of Appeal Reconsideration Appeal for Summary Suspensions. Within 15 days after the appeal reconsideration appeal review is concluded, the

Credentialing Supervisor, or his or her designee, shall make a written report of the Appeal Reconsideration Committee's findings and decisions in the matter, and such report shall be placed in the Participating Provider's File. The report shall include a statement of the basis for the Appeal Reconsideration Committee's decision(s).

8. Effect of Result for Summary Suspensions.
  - a. If a decision of the Appeal Reconsideration Committee is favorable to the Participating Provider, notice shall promptly be sent to the Participating Provider informing him/her/it of action taken. Copy of notice will be kept in the Participating Provider's File.
  - b. If a decision of the Appeal Reconsideration Committee is favorable to the Participating Provider, such results shall become the final decision of the Appeal Reconsideration Committee and the matter shall be closed.
  - c. If the decision of the Appeal Reconsideration Committee continues to be adverse to the Participating Provider, the Appeal Reconsideration Committee shall cause notice of the decision to be given to the Participating Provider via signature confirmation mail, within 30 days. The notice shall describe the action from the Appeal Reconsideration Committee and the reason for it. The notice shall also state the network will continue to monitor the Participating Provider's credentials until such time the network has enough information regarding the summary suspension event to review the matter in full and make a decision about the Participating Provider's network participation status. A copy of the notice will be kept in the Participating Provider's File.
9. Reconsideration Appeal Requirements for Participating Provider Terminations.
  - a. Notice of Time and Place for Appeal. Upon receipt from a Participating Provider of a timely and proper request for an appeal, the Credentialing Supervisor, or his or her designee, shall schedule and arrange for an appeal. At least 30 days prior to the reconsideration appeal, the Credentialing Supervisor shall send the Participating Provider written notice of the time, place and date of the hearing, by signature confirmation mail, which date shall be not less than 30 days after the date of the notice;. The notice of the hearing provided to the Participating Provider shall include a list of witnesses (if any) expected to testify at the appeal in support of the proposed action and a summary of the Participating Provider's rights according to these Policies and Procedures.

- b. Statement of Issues and Events. The notice of appeal shall contain a concise statement of the Participating Provider's alleged acts or omissions and/or a concise statement of any other reasons or subject matter forming the basis for the adverse action which is the subject of the hearing.
- c. List of Witnesses. In addition to the list of witnesses required in the notice of appeal, at least 10 days prior to the scheduled date for commencement of the appeal, each party shall provide the other with a list of names of the individuals who, as far as then reasonably known, will give testimony or evidence in support of that party at the appeal. Admissibility of testimony to be presented by a witness not so listed shall be at the discretion of the Hearing Officer, as defined below.

10. Appeal Procedure for Participating Provider Terminations.

- a. Forfeiture of Hearing. A Participating Provider who requests an appeal pursuant to this Article but fails to appear at the hearing without good cause, as determined by the Hearing Officer, shall forfeit his/her rights to such appeal to which he or she might otherwise have been entitled. If the Hearing Officer determines that the failure to appear is without good cause, the decisions shall become final upon the expiration of 30 days from the decision of the Hearing Officer. The Credentialing Supervisor shall notify the Participating Provider of the decision of the Hearing Officer.
- b. Hearing Officer. The Hearing Officer shall be the presiding officer. He or she shall act to maintain decorum and to assure that all participants in the appeal process are provided a reasonable opportunity to present relevant oral and documentary evidence. He or she shall be entitled to determine the order of procedure during the appeal and shall make all rulings on matters of law, procedure, and the admissibility of evidence.
- c. Representation. The Participating Provider who requested the appeal shall be entitled to be accompanied and represented at the hearing by a member of his or her professional society, and/or by an attorney. The Network may designate an attorney to represent it at the appeal to present the facts in support of its adverse action, and to examine witnesses.
- d. Rights of Parties. During the appeal each party may:
  - i. Call, examine and cross-examine witnesses;
  - ii. Introduce any relevant evidence, including exhibits;

- iii. Question any witness on any matter relevant to the issues that are the subject of the hearing;
- iv. Impeach any witness;
- v. Offer rebuttal of any evidence;
- vi. Have a record made of the hearing in accordance with Section h. of this Article; and
- vii. Submit a written statement at the close of the hearing.

If a Participating Provider who requested the appeal does not testify in his or own behalf, he or she may be called and examined as if under cross-examination.

- e. Procedure and Evidence. At the appeal, the rules of law relating to examination of witnesses or presentation of evidence need not be strictly enforced, except that oral evidence shall be taken only on oath or affirmation. The Hearing Officer may consider any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs regardless of whether such evidence would be admissible in a court of law. Prior to or during the hearing, any party may submit memoranda concerning any procedural or factual issue, and such memoranda shall be included in the hearing record.
- f. Information Pertinent to Appeal. In reaching a decision, the Appeal Reconsideration Committee shall be entitled to consider any pertinent material contained on file in the Network and information that can be considered pursuant to these Policies and Procedures. The Appeal Reconsideration Committee may at any time take official notice of any generally accepted technical or scientific principles relating to the matter at hand of any facts that may be judicially noticed by Missouri courts. The parties to the appeal shall be informed of the principles or facts to be noticed and the same shall be noted in the hearing record. Any party shall be given the opportunity, upon timely request, to request that a principle or fact be officially noticed or to refute any officially noticed principle or fact by evidence or by written or oral presentation of authority in such manner as determined by the Hearing Officer.
- g. Burden of Proof. When an appeal relates to an adverse action the Chairperson or Co-Chair shall have the initial obligation to present evidence in support thereof, but the Participating Provider thereafter is responsible for supporting his or her challenge that the adverse action

lacks any substantial factual basis or that the basis or the conclusions drawn there from are arbitrary, unreasonable, or capricious.

- h. Record of Appeal. A record of the appeal shall be kept of sufficient accuracy that an informed and valid judgment can be made by any group that may later be called upon to review the record and render a decision in the matter. The Hearing Officer shall select the method to be used for making the record, such as a court report, electronic recording unit, detailed transcription, or minutes of the proceedings. Upon written request, the Participating Provider shall be entitled to obtain a copy of the record or use an alternative recording method, at his or her own expense.
  - i. Postponement. Requests for postponement of an appeal may be granted by the Hearing Officer upon showing of good cause and only if the request is made as soon as is reasonably practical.
  - j. Presence of Hearing Committee Members and Vote. A majority of the Appeal Reconsideration Committee shall be present at all times during the appeal and deliberations. If a committee member is absent from any part of the proceedings, the Hearing Officer in his or her discretion may rule that such member be excluded from further participation in the proceedings or decisions of the committee.
  - k. Recesses and Adjournment. The Appeal Reconsideration Committee may recess the hearing and reconvene it without additional notice if the committee deems such recess necessary for the convenience of the participants, to obtain new or additional evidence, or if consultation is required for resolution of the matter. When presentation of oral and written evidence is complete, the hearing shall be closed. The Appeal Reconsideration Committee shall deliberate outside the presence of the parties and at such time and in such location as is convenient to the committee. The Hearing Officer shall not participate in the deliberations. Upon conclusion of the Appeal Reconsideration Committee's deliberations, the appeal shall be adjourned.
11. Report of Suspended Termination Period for Participating Provider Terminations. If adverse information is received during a Participating Provider's suspended termination period, or if at the end of a suspended termination period, no adverse information was received, a teleconference shall be held with the committee ensuring that all parties can hear and communicate with each other, and the committee shall determine the basis for any decision. Within 15 days after the suspended termination review is concluded, a written report of the committee's decisions and findings shall be placed in the Participating Provider's File.

12. Report of Appeal Review for Participating Provider Terminations. Within 15 days after the appeal review is concluded, the Credentialing Supervisor shall make a written report of the Appeal Reconsideration Committee's findings and decisions in the matter, and such report shall be placed in the Participating Provider's File. The report shall include a statement of the basis for the Appeal Reconsideration Committee's decision(s).

13. Effect of Result for Participating Provider Terminations.

- a. If a decision of the Appeal Reconsideration Committee is favorable to the Participating Provider, notice shall promptly be sent to the Participating Provider informing him/her/it of action taken. Copy of notice will be kept in the Participating Provider's File.
- b. If a decision of the Appeal Reconsideration Committee is favorable to the Participating Provider, such results shall become the final decision of the Appeal Reconsideration Committee and the matter shall be closed.
- c. If the decision of the Appeal Reconsideration Committee continues to be adverse to the Participating Provider, the Appeal Reconsideration Committee shall cause notice of the decision to be sent to the Participating Provider via signature confirmation mail. Such results shall become the final decision of the Appeal Reconsideration Committee. Copy of notice to the Participating Provider shall be kept in the Participating Provider's File. Additionally, the Network shall (i) report this adverse action to the Healthcare Integrity and Protection Data Bank as required by Federal Law; and (ii) terminate the Participating Provider Agreement with the Participating Provider.

## **XX. Ability to Reapply**

If any action under these Policies and Procedures is deemed final and is an adverse action with respect to a Provider, the Provider may not reapply to the Network until after a one-year waiting period from the date the Provider is notified of the final denial action. The Provider shall not be permitted to reapply prior to the end of such one-year period.