CREDENTIALING

Section VIII

I. PURPOSE

Community Health Plan shall maintain a process to determine compliance with eligibility criteria, which will be consistently applied to all health care professionals for initial and continued participation as providers of our HMO.

The primary objectives of the initial selection, retention, re-appointment and termination policies are to:

- Ensure each Community Health Plan provider is qualified by education, training, license, professional standing, and experience to deliver quality medical services;
- Maintain only competent and qualified providers through appropriate parameters of credentialing and application of performance standards without discrimination based on race, creed, color, religion, national origin or gender orientation; and
- Provide a means to address issues of peer review appropriate to the Provider Relations/Quality Review Committee relative to the practitioner's professional conduct, physical and psychological health status, and current clinical competence.

II. DEFINITIONS

Allied Health Provider: Masters level certified clinical nurse specialists or psychiatric nurse practitioner (FNP, CPNP, CRNA, CNM, APN, WHNP), Physician Assistant (PA), Speech Pathologist (SP), who are state licensed to treat members outside an inpatient setting in the state in which the provider practices.

Applicant Provider: A Provider who submits an application for initial appointment or re-appointment as a Participating Provider.

Behavioral Health Provider: Doctoral and/or master's level psychologists (PhD, PY, PsyD), master's level clinical social workers (LCSW), professional counselors (LPC), licensed clinical professional counselor (LCPC), marriage and family therapists (LMFT), and mental health counselors (LMHC, CSAC) who are state certified or state licensed to treat members. The following credentials are also recognized in the state of Kansas: licensed master social worker (LMSW), licensed specialist clinical social worker (LSCSW) and licensed master level psychologist (LMLP).

Participating Provider: A Provider who has been approved, through either the initial appointment or re-appointment process, for participation status and holds a contract in Community Health Plan.

Physician: An individual who holds either a doctor of medicine (M.D.), doctor of osteopathy (D.O.), doctor of dental surgery (D.D.S.), doctor of podiatric medicine (D.P.M.), or doctor of chiropractic medicine (D.C.) degree from an accredited institution and possesses a valid license to practice medicine, dentistry, podiatry or chiropractic medicine.

III. ELIGIBILITY FOR INITIAL CREDENTIALING

The scope of provider credentialing applies to all licensed, independent practitioners or groups of practitioners who wish to provide care to Community Health Plan members and are requesting initial credentialing status with Community Health Plan. Applicants are required to:

- Deliver a fully completed, signed application to the Plan.
- Maintain staff appointment in good standing at a Community Health Plan network hospital, if applicable.
- Provide documentation of successful training completion in the area practiced from an accredited school. All foreign/international documentation must be accompanied by written, English translation.
- Provide documentation of successful completion of postgraduate residency training or specialty board certification in the area practiced, as applicable.
- Provide work history including the beginning and ending month and year for each position. A gap exceeding 30 days must be explained.
- Maintain current, professional licenses and controlled substance registration as applicable to practice profession.
- Provide information documenting individual professional liability coverage.
- Document that he/she has not been convicted of any criminal offense punishable as a felony, or has engaged in any improper act substantially related to the qualifications, functions or duties of a provider.
- Maintain absence of Medicare/Medicaid sanctions, fines or suspension from either program.
- Attest that all information included on the application is correct and complete.
- Applicants must provide information regarding:
  - Incidence raising issues of competence or adherence to the ethics of the profession.
  - Physical or mental impairments due to chemical dependency or substance abuse.
  - Provide National Practitioner Identification (NPI) number.

IV. CONFIDENTIALITY OF INFORMATION

Confidentiality of Credentials

- To preserve the integrity of the credentialing process and avoid inappropriate dissemination of information, all information regarding the credentialing of all providers will be treated as confidential information in accordance with the Plan's policies and procedures:
- All staff, upon employment, agree to abide by Heartland Health's confidentiality policy/procedure that details the importance of confidentiality.
- All personnel involved in credentialing activities will be informed of their responsibility in maintaining the confidentiality of all information reviewed pursuant to the credentialing process and their obligation to prevent unauthorized disclosure of such information.
- The minutes of any Provider Relations/Quality Review Committee meeting or proceedings to evaluate an applicant's credentials shall be treated as confidential information and not disclosed to unauthorized personnel, except as required by law.
- All provider specific information will be considered confidential. This information will be used solely for the purposes of utilization management, case management and quality improvement. It will be shared only with those parties who have the authority to receive such information.
- If disclosure is required through a court order, the request will be forwarded to Community Health Plan's legal counsel for review and approval with a copy to the Plan Administrator.
- Access to on-line confidential provider information is restricted to authorized staff only. Employees shall preserve the integrity of their personal passwords by not allowing them to be known to unauthorized personnel.
- Before discarding any information obtained in the credentialing process, such materials will be shredded or otherwise rendered anonymous in accordance with Federal and State laws.
- All information that is transferred by FAX shall be transmitted using the Community Health Plan FAX cover sheet.

On-Site Review

An on-site office review of Primary Care Practitioners (PCP) and Obstetricians/Gynecologists (OB/GYN) provider is conducted at the time of initial credentialing. An on-site office review of PCP, OB/GYN and high-volume Behavioral Health care practitioners is conducted at the time of recredentialing.

The on-site review is conducted by Community Health Plan Provider Services Representative. The on-site review assures members of:

- Physical accessibility;
- Physical appearance;
- Adequacy of waiting room and examining room space;
- Adequacy of medical records filing;
- Content and format of medical record; and
- Availability of appointments.
- Member complaints.

V. NATIONAL PRACTITIONER DATA BANK (NPDB) AND HEALTHCARE INTEGRITY AND PROTECTION DATA BANK (HIPDB) PROCEDURES

- The National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank will be queried to screen initial application and all individuals making reapplication to Community Health Plan at least every three years.
- The National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank may be queried at other times if deemed appropriate during any period of appointment.
- Mandatory reporting will be conducted for all providers as required by Title IV of Public Law 99-660, Health Care Quality Improvement Act of 1986, as amended. A report will be sent to the applicable licensing board when the following professional review actions are taken:
  - An applicant's participation is restricted/denied based on professional competence and/or conduct;
  - Professional review action, based on reasons related to professional competence or conduct, adversely affecting clinical privileges for a period longer than thirty (30) calendar days; or voluntary surrender or restriction of clinical privileges; while under or to avoid investigation.
- Reporting adverse actions for providers as required by law to the National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank occurs only after final determination has been made by the Board of Directors.
- After a final determination by the Board of Directors in accordance with the law, the adverse action will be reported within fifteen (15) days from the date the action was taken that adversely affects the practitioner's participation for a period longer than thirty (30) calendar days.

VI. RECREDENTIALING PROCESS

Community Health Plan recredentials providers every three years. The Credentialing Coordinator establishes and maintains a schedule regarding recredentialing so that the work load is staggered, yet compliant with the required time frame of every three years. A provider must continue to meet the eligibility and participation criteria for initial appointment in order to be approved for continued participation.

All providers that provide health care services in an ambulatory setting shall complete an application for recredentialing. Exception: Practitioners who provide care to members only as a result of the members being directed to the hospital or freestanding facility do not have to be credentialed (i.e.; radiologists, pathologists, anesthesia providers, emergency room providers, hospitalists).

Provider eligibility criteria for reappointment and continued participation:

- Written verification that clinical privileges are in good standing at the hospital designated as the provider's primary admitting facility. If documentation of restrictions, revocation, involuntary reduction or non-renewal at any health care facility privileges is noted, further investigation from facility noted is conducted.
- Documentation of Board Certification status
- Current professional licenses and controlled substance registration (DEA and BNDD) as applicable to practice their profession. Provider will provide details if license or registration to practice in any jurisdiction has ever been suspended, terminated or limited;
- Information documenting current individual professional liability coverage, to include policy limits of liability, insured's name, carrier, address, policy period (inception and expiration dates) and policy numbers during the previous five (5) year period.
- Documentation of absence of Medicare or Medicaid sanctions, fines or suspension from either program;
- Inquiry from the National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank.
- The following data is also reviewed in the recredentialing process:
    - member complaints;
    - information from quality improvement activities;
    - on-site review
    - performance improvement data

Providers are informed of the above findings upon being recredentialed. A plan for improvement, evidence of changes in the scope of practice, required continuing education, and/or continued participation with Community Health Plan is reviewed with the practitioner by the Medical Director, if necessary.

Review of recredentialing findings shall be conducted by the Provider Relations/Quality Review Committee. The Board of Directors makes final determinations regarding continued participation of individual providers.

VII. PRACTITIONER FAIR HEARING POLICY AND HEARING RULES AND PROCEDURES

The following notice and hearing procedures, or such other procedures as are fair to the provider under the circumstances, and comply with applicable law, shall be afforded to the Provider involved unless waived by the provider.

Notice Requirements and Pre-Hearing Procedures

- If a provider is entitled to a Fair Hearing, the provider shall be given written notice by certified mail, return receipt requested, by the Plan Administrator within 5 days of the date of the final action or recommendation. The notice shall specify the action taken and the reasons for the decision. The notice shall inform the provider that the final action of the Board of Directors is or will be a "professional review action" as defined by the Health Care Quality Improvement Act, and must be reported to the National Practitioner Data Bank and the relevant state regulatory body. The notice shall advise the provider, that he has 30 days from the date of the notice to present the Plan Administrator with a written request for a Fair Hearing, and that failure to provide such a request shall constitute a waiver of the provider's right to a hearing.
- If the provider fails to request a hearing within the time and in the manner provided in this Policy, the provider will be deemed to have waived any right to a hearing to which the provider might otherwise be entitled. The provider may also, at any time, waive any further right to a hearing by written notice to the Plan Administrator.
- If the provider requests a hearing on a timely basis, the Plan Administrator shall schedule a hearing no later than 30 days following the date of receipt of the provider's request for a hearing. This time may be extended with the agreement of the provider. The Plan Administrator shall send a written notice to the provider of the date, place and time of the hearing no later than 15 days prior to the date of the hearing. The written notice shall include a copy of Community Health Plan's Fair Hearing Rules and Procedures.
- The hearing may be rescheduled from time to time by agreement. Written notice of the new date, place and time shall be sent to the provider no later than 15 days prior to the new date.
- At least 10 days prior to the date of the hearing, the Plan Administrator shall provide the provider with a list of the names and addresses of the witnesses who will be expected to testify. Upon written request by the Plan Administrator, at least 10 days prior to the date of the hearing, the provider will provide Community Health Plan with a list of the names and addresses of the witnesses who will be expected to testify.

Hearing Rules and Procedures

- The hearing will be held before a panel of 3 persons, one of whom will be a clinical peer in the same or similar specialty, none of who is in direct economic competition with the provider, and none of who have actively participated in the consideration of the matter at any previous level. Knowledge of the matter shall not preclude appointment.

- Community Health Plan may appoint one member of the panel to serve as Chairman, or appoint a neutral Hearing Officer. The Hearing Officer may be an attorney-at-law and may be legal advisor to the panel but shall not be entitled to vote, and shall not act as a prosecuting officer or as an advocate for Community Health Plan.
- The Chairman or the Hearing Officer shall preside at the hearing and shall:
  - ensure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross-examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;
  - maintain decorum throughout the hearing;
  - determine the order of presentation throughout the hearing;
  - have the authority and discretion, in accordance with these Procedures, to make rulings on all questions which pertain to matters of procedure and to the admissibility of evidence;
  - act in such a way that all reasonably relevant information is admitted and available for consideration; and
  - conduct argument on procedural points.
- The Chairman or Hearing Officer may:
  - postpone or recess the hearing;
  - set reasonable time limits on the presentation of evidence and introduction of exhibits;
  - question the witnesses and call additional witnesses as he/she deems appropriate; and
  - take official notice of any matters, either technical, or scientific, relating to the issues under consideration that could have been judicially noticed by the courts of the State. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.
- The provider who requested the hearing and Community Health Plan may each be represented by an attorney or other person of their choice.
- A record will be kept by a stenographic reporter. The cost of the reporter will be borne by Community Health Plan. The provider who requested the hearing may order copies of the transcript from the reporter at his/her expense.

- Subject to the provisions herein, each party shall have the following rights:
  - To call and examine witnesses who will testify under oath or upon affirmation;
  - To present evidence and introduce exhibits deemed to be relevant by the Chairman or Hearing Officer, regardless of their admissibility in a court of law;
  - To cross-examine any witness on any matter relevant to the reason(s) for which hearing is being conducted and to rebut any evidence; and
  - To submit a written statement at the close of the hearing. The Chairman or the Hearing Officer may request a written statement and may allow either party to make oral argument.
- Unless otherwise determined by the Chairman or the Hearing Officer, Community Health Plan will open with evidence in support of its action. Thereafter, the burden shall shift to the provider who requested the hearing to present evidence.
- The hearing will not be conducted according to the rules of evidence relating to examination of witnesses or the presentation of evidence. Any relevant evidence shall be admissible, including hearsay, if it is the sort of evidence on which responsible persons are accustomed to rely in the credentialing of a provider.
- Community Health Plan and the provider may submit a memorandum of points and authorities at any time prior to the conclusion of the hearing. The Chairman or Hearing Officer, may grant additional time to submit a memorandum upon written request of either party.
- The hearing shall be closed to the public. All documents and testimony shall be maintained in strict confidence by all participants, and witnesses consistent with the applicable state and/or federal peer review protection statute.
  - Upon conclusion of the presentation of oral and documentary evidence by each party, the hearing shall end.
  - The provider shall have the burden to come forward with clear and convincing evidence in support of his position.

Post Hearing Procedures

- The panel shall render written findings of fact and recommendations within 15 days following the close of the hearing. The Panel shall recommend in favor of Community Health Plan if it determines that the adverse action was taken in the reasonable belief that it was in furtherance of quality health care or the result of provider’s breach of his contract. This is a provision for a mandatory finding only. It does not require such a finding in order to find for Community Health Plan, and failure to so find shall not preclude the panel from making a discretionary finding for Community Health Plan on any grounds.
- The Hearing Officer shall send the panel’s written findings and recommendations to the Plan Administrator of the Plan, who shall immediately forward it to the providers and to the Board of Directors for consideration.

- The Board of Directors shall carefully consider the findings and recommendations of the panel and may, in its discretion, review all or a portion of the evidence submitted at the hearing and the transcript of the hearing. The Board of Directors shall then, within thirty (30) days of receiving the findings and recommendations, vote to affirm, modify or reverse the panel's recommendations.
- The Executive Vice-President shall, within five (5) days of the Board's action, forward a written statement to the provider notifying the provider of the Board's action and, if adverse, the reasons for said action.

Reporting Procedures

- The Plan Administrator, or his/her designee shall, in the form required by 42 U.S.C. 11134, report the following to the applicable licensing agency of each state in which a provider holds a valid medical, dental, podiatric or chiropractic license and to the National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB):
  - any adverse final action by the Board of Directors as defined in this policy/procedure, provided that:
    - The provider has waived his/her right to a Fair Hearing; or
    - The Board has taken such action after a Fair Hearing has taken place and the Hearing Officer has forwarded findings and recommendations to the Board.
    - The provider voluntary terminates his/her status as a provider after the provider is notified that a complaint or concern relating to the provider's competence or professional conduct has been received by Community Health Plan.

VIII. TERMINATION AND REINSTATEMENT

Community Health Plan shall experience voluntary termination by providers as well as initiate termination of providers.

A provider may terminate his/her participation at any time by giving the Plan written notice as noted in the Provider's contract. Notice of the reason for termination by the provider is not required.

Reduction, suspension, or termination of participation may occur by written notice to the provider by the Plan Administrator.

All individuals requesting reinstatement shall make application for participation which will be processed as an initial application.

Reinstatement After Adverse Determination

A provider, who has been subject to an involuntary termination, may make application for participation after a period of twelve (12) months after the date of final action, after there has been full reinstatement by the licensing or other regulatory agency that precipitated the adverse decision. All applications shall be processed as an initial application and the applicant must include information to demonstrate the basis for reinstatement.