

CREDENTIALING PLAN

PHYSICIAN CREDENTIALING PROCESS- Currently under review

Introduction

The MCO Credentialing Committee will be responsible for initial credentialing, and recredentialing process, discipline and termination of participating physicians and other health care practitioners. In selecting these practitioners, the MCO does not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his or her license or certification under state law, solely on the basis of the license or certification. Physicians approved by the Credentialing Committee will be notified in writing by Chief Medical Officer.

1. The objectives of the Credentialing Committee will be:
 - a) To ensure that members who enroll with the MCO will have their care rendered by appropriately qualified practitioners.
 - b) To ensure that each practitioner applicant has equal opportunity to participate.
 - c) To ensure that adequate information pertaining to education, training, relevant experience, and other credentialing criteria is reviewed by the appropriate individuals prior to approval or denial by the Credentialing Committee.

2. Providers covered under this plan are practitioners who have an independent relationship with the MCO. An **independent relationship** exists when the MCO selects and directs its members to see a specific practitioner or group of practitioners, including all practitioners whom members can select as primary care practitioners (PCP). This includes:
 - a) practitioners who see members outside the inpatient hospital setting or outside ambulatory freestanding facilities.
 - b) practitioners who are hospital-based but who see MCO members as a result of their independent relationship with the organization.
 - c) dentists who provide care under the organization's medical benefits.
 - d) Non-physician practitioners who have an independent relationship with the organization, as defined above, and who provide care under the organization's medical benefits.

3. Practitioners who meet any of the following criteria are not included in the credentialing and recredentialing processes:

- a) practitioners who practice exclusively within the inpatient setting and who provide care for the MCO members only as a result of the members being directed to the hospital or another inpatient setting
 - b) practitioners who practice exclusively within freestanding facilities and who provide care for the MCO members only as a result of members being directed to the facility
 - c) dentists who provide primary dental care only under a dental plan or rider
 - d) pharmacists who work for a pharmacy benefits management (PBM) organization to which the MCO delegates utilization management (UM) functions
 - e) covering practitioners (e.g., locum tenens)
 - f) practitioners who do not provide care for members in a treatment setting (e.g., board-certified consultants).
4. In accordance with NCQA standards, the following disciplines are subject to a credentialing review. Primary source verification, however, varies depending upon the discipline and the Credentialing Committee may develop specific criteria for ancillary providers.
- a) Primary Care Providers (MD, DO)
 - b) Internal Medicine
 - c) Pediatrics
 - d) Family Practice
 - e) Ob/Gyns (MD, DO)
 - f) Referral Specialists (MD, DO)
 - g) Podiatrists (DPM)
 - h) Dentists (DDS, DMD)
 - i) Chiropractors
 - j) Podiatrists
 - k) Certified Nurse Midwife (CNM)
 - l) Nurse Practitioners (NP)
 - m) Physician Assistants (PA)
 - n) Psychiatrists
 - o) Psychologists
 - p) Licensed Clinical Social Workers
 - q) Other Behavioral Health Practitioners who are licensed or certified to practice independently

Credentialing Committee

1. The Credentialing Committee is a standing committee of the MCO and is responsible for administering the Credentialing Plan.
2. The Credentialing Committee will be made up entirely of physicians. The MCO, Chief Medical Officer will solicit board-certified physicians representing key specialties who are participating in the Network.
3. The Chief Medical Officer will serve as Chairman of the Credentialing Committee.
4. The Credentialing Committee is a peer review committee, and ultimate responsibility for the approval of its recommendations will rest with the Quality Management and Improvement Committee.
5. The confidentiality of all information presented to, or discussed at, the Credentialing Committee will be strictly maintained, and no member will disclose, or use information except at the direction of the committee, and for the purposes outlined in this document.
6. Three physician members will constitute a quorum for transacting routine business, but no less than seven members must be present when a recommendation is made to deny appointment, or to discipline a physician, or terminate appointment.
7. The Credentialing Committee will meet monthly or as often as necessary to complete its work.
8. The Credentialing Committee will interface with the Medical Management Committee on Utilization/Quality Management issues.
9. The Credentialing Committee will report to the Quality Management and Improvement Committee.

Application

1. Each physician applicant must complete an application that includes:
 - a) An unlimited release granting the Credentialing Committee permission to review relevant records, to contact professional societies, hospitals, insurance companies, or other entities which do, or may have records concerning the applicant.
 - b) A release from liability for any individual or agency that provides information as part of the application process.
 - c) A release with respect to reports which may have to be submitted to the licensing boards or the National Practitioner Data Bank for reasons relating to an applicant's professional conduct or competence.
 - d) Each application must be accompanied by:
 - e) A copy of the applicant's current professional license/registration;
 - f) A copy of the applicant's current Drug Enforcement Agency (DEA) registration if applicable;
 - g) A copy of the face sheet of the applicant's current professional liability insurance policy.
- 2 The Credentialing process for each application will be completed within 150 days from receipt of the application and all supporting documentation.

Physician Selection Criteria

- 1 Evaluation of a completed and signed physician application for Network participation includes assessment of the following criteria:
 - a) Licensure (PSV)
 - 1 All physician applicants must hold a current medical license in the state(s) in which they are applying for participation. A copy of the current registration of license must be submitted with the application to participate and will be included in the physician credentialing file.

- 2 The Provider Relations Department will also verify license status by contacting the appropriate state licensing agency or Medical Board either in writing or by telephone.

b) Post-graduate Training (PSV)

- 1 All physicians considered for initial credentialing are expected to have completed an accredited post-graduate residency or fellowship program in their designated practice specialty or sub-specialty. Specialty in this context is defined as both primary care specialties (General Medicine, General Pediatrics and Family Practice) and the non-primary care specialties.
- 2 Accredited programs will include those that meet the standards of the Accreditation Committee on Graduate Medical Education (ACGME) or the Council on Postdoctoral Training of the American Osteopathic Association.

Board Certification (PSV)

- 1 All physicians considered for initial credentialing must be board certified or board eligible, as defined below, in each specialty and subspecialty for which they are seeking Network participation, or they must meet the board certification exception criteria described below.
- 2 Board certification will mean certification provided by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA). The Network may conduct primary verification of Board certification using the American Board of Medical Specialists (ABMS) Compendium of Certified Medical Specialists, the American Osteopathic Association Yearbook, and the Directory of Osteopathic Physicians.
- 3 Board eligibility will mean completion of an approved residency or fellowship program in the specialty or subspecialty, no more than five years before the date of the application for Network participation. Physicians who are more than five (5) years beyond the completion of their specialty or subspecialty training, and who have not achieved board certification, are not considered board eligible as defined by the Network for the purpose of credentialing.
- 4 Physicians who are not board certified or board eligible by the above Network definition may be selected as Network participants after review by the Credentialing

Committee and/or approval by the Chief Medical Officer or his/her designee if they meet the Board Certification Exception Criteria listed below.

- (1) All three of the following criteria must be fulfilled in order to qualify for Board Certification Exception:
 - a. A letter of support from the physician's Department Chief. This must be the Department representing the specialty or sub-specialty in which the physician is applying for credentialing. This must also be a Department of the Hospital where the physician is privileged.
 - b. If the physician is not a member of such a Department, then the MCO Chief Medical Officer will determine if a facility Medical Officer or another appropriate medical supervisor can substitute as a supporting reference.
 - c. This letter has a standardized format and is included as Exhibit A. (Under Review)
 - d. A letter of support from the Director of the Residency Program which the applicant completed. This letter has a standardized format and is included as Exhibit B.
 - e. Provide documentation of completion of 100 hours of CME over the previous two years. At least 50 of these hours must be in the specialty for which credentialing is being considered.
 - f. The Chief Medical Officer may waive the Board Certification requirement if either of these two conditions is present:
 1. There is insufficient coverage of a particular specialty in a given geographic area that significantly limits access for members.
 2. The applicant is a member of a group practice and the majority of the group partners participate in the managed care network.
 - g. In instances when such a waiver is applied, the Chief Medical Officer must present the case, with appropriate justification, to the Credentialing

Committee. If the Committee has concerns about the justification of the waiver or the clinical competence of the applicant it may veto the Chief Medical Officer's waiver with a simple majority vote.

Malpractice Coverage

1. Participating physicians are required to carry a current minimum malpractice coverage of \$1 million/\$3 million unless the local community coverage standards can be demonstrated to be substantially lower. Malpractice insurance must be relevant to the scope of practice for which the physician has applied to AMERICAN HEALTH MEDICARE.
2. Each applicant will submit, with the application, a copy of the face sheet of the current policy indicating expiration date, policy number and coverage limits. Primary verification of current coverage and policy limits will be conducted to the extent possible.
3. In order to facilitate this verification, applicants will sign a release form instructing the malpractice carrier to provide coverage information.

Malpractice History

1. Each physician applicant's malpractice history will be assessed as part of the credentialing process. Malpractice history will include any malpractice actions, judgments or settlements against the physician. Self-reporting of the malpractice history is required as part of the application.
2. A provider whose malpractice history indicates two or more actions, judgments and/or settlements during the ten (10) years preceding the application will be reviewed by the Chief Medical Officer and, when appropriate, by the Credentialing Committee. To conduct this review, the Chief Medical Officer may request additional information from the applicant physician.
3. Such physicians may be accepted as participating physicians on the recommendation of the Committee and approval of the Chief Medical Officer or his designee. In their evaluation, the Committee will take into account the circumstances of the malpractice cases, the physician's specialty and length of time in practice, the disposition of the cases, (the amounts of the judgments and/or settlements), the total number and frequency of

claims, and other relevant information provided by the applicant or other appropriate state and/or federal sources.

Drug Enforcement Agency Certification

1. Each applicant must provide, with the application, a copy of a current, valid federal DEA Certificate. In addition, if applicable, a current, valid state/commonwealth DEA Certificate will be required when applicable.
2. Primary verification of the DEA certificate status will be accomplished by visual inspection of the original certificate(s) at the time of the on-site office review or by reports available through the National Technical Information Service (NTIS).
3. All exceptions require review by the Credentialing Committee and the approval of the Chief Medical Officer or his designee.

Hospital Privileges

1. Each physician must have unrestricted hospital privileges in one or more participating Network hospitals (except for physicians whose practice does not typically include inpatient care (e.g. Dermatology, Allergy, Radiology)).
2. A physician whose hospital privileges in his or her specialty have been sanctioned, restricted, or revoked as a result of a clinical disciplinary action, will not be considered for appointment until unrestricted privileges have been restored.
3. Physicians who hold only courtesy privileges in a participating network hospital will not be selected as participating providers. The hospital will be asked to verify that the applicant's privileges are unrestricted and in good standing.

Work History

Each physician must submit curriculum vitae which list, without gaps (M/YYYY), all places of employment and responsibilities, including teaching, clinical practice, administrative medicine, research, industry or government positions during the past 5 years.

Medicare Participation Status

1. The MCO will submit all the names of all physicians to the Department of Social Services to determine Medicare participation status.

Federal, State/Commonwealth or Local Sanctions

1. Any physician who has been sanctioned by any state/commonwealth or federal agency will not be accepted into the network as a participating provider, except on the recommendation of the Credentialing committee and the Chief Medical Officer or his designee, and assuming unrestricted privileges at a network institution.
2. Sanctions include medical license or practice privilege probation, revocation, restriction, sanction, or reprimands. Sanctions also include Medicare or Medicaid reprimands, censure, disqualification, suspension or fines, as well as conviction of or indictment for a felony.
3. Only physicians with unrestricted privileges at network institutions are eligible for participation.
4. When privileges are suspended for any reason, participation in the MCO is also suspended.

Site Visit Assessment

1. The physician applicant must provide documentation that coverage arrangements by participating physicians and office hours, where applicable, are consistent with the ability to provide coordination and continuity of care. The information such as access, availability, waiting time, cleanliness, signage and infection control will also be documented.
2. Primary care physicians and obstetricians/gynecologists must be in their primary office sites caring for patients a minimum of twenty (20) hours per week. Patients should not wait for more than 30 minutes past their scheduled appointment time without an explanation about the delay and an offer to reschedule the appointment within the following period of time:

Urgent but not emergent care – within 24 hours
Non-urgent care but in need of attention – within one week
Routine and Preventive – within 20 days
Specialty Consults (non-urgent) – within 20 days
Office Waiting Time – 30 minutes
Non-urgent Mental Health and Substance Abuse visit – 20 days

3. In addition, an on-site review of the practice location(s) of primary care physicians, obstetricians and certain high volume specialists including but not limited to cardiology, otolaryngology, hematology, medical oncology, and gastroenterology will be conducted to evaluate the office environment and the medical record keeping practices. Standard audit instruments will be used to conduct these reviews.
4. These office assessments will be conducted pre-contractually, and physicians will not be accepted as Network participants prior to this review, pending the satisfactory outcome of the site visit.
5. If a provider does not pass the site visit, a letter will be sent to the provider explaining the office deficiencies and requesting evidence of correction. The provider is not eligible for network participation until the deficiency is corrected.
6. In addition, the MCO will evaluate the effectiveness of the actions at least every six months until sites with deficiencies meet the thresholds set by the Plan.
7. When a primary care physician, obstetrician or specific high volume specialist relocates or opens a new site that site will be treated as an initial site.
8. The MCO has procedures for identifying deficiencies (e.g. Provider Orientation, Provider Education, Provider Outreach) following the initial site visit. If new deficiencies are identified, the Plan will reevaluate the site and institute actions for improvement as outlined above.

Impaired Physical or Mental Health

1. Physicians whose physical or mental health is, upon review by the Credentialing Committee and upon the judgment of the Chief Medical Officer, impaired to such an extent that the impairment poses a risk of harm to patients, will not be accepted as Network participants.
2. Only physicians with unrestricted privileges at network institutions are eligible for participation in the Network. When privileges are suspended for any reason, participation in the Network is also suspended.

Recovering Physicians

1. Physicians who are recovering from alcohol and/or chemical dependency may be accepted as Network participating providers with the approval of the MCO Chief Medical Officer following review by the Credentialing Committee.
2. The Committee will undertake an extensive and objective review of each case and reach a recommendation based on information that will be requested from the physician and other sources.
3. Re-instatement will follow careful evaluation of certificates of completion of an approved program (e.g., for substance abuse), or the recommendations of a Plan-approved psychiatrist (for mental impairment). In those cases where there is contention, the policies and protocols established by the American College of Physicians will be followed in the identification and management of the impaired physician.

Minimum requirements

1. The criteria listed above represent the minimum guidelines that must be met by a physician applicant.
2. There are other valid considerations not listed, including network size, market demands and access issues, which involve business decisions and may influence the selection process.
3. The applicant must demonstrate acceptable character and competency.

4. The MCO will consult with Credentialing Committee and solicit advice from key participating physicians with respect to the credentialing criteria used for credentialing and recredentialing of individual healthcare professionals.

Administrative Action

1. The MCO Credentialing Coordinator will determine the completeness of each application based on the criteria set forth in previous sections and including the outcome of primary source verification. If an application is complete it will be forwarded to the Credentialing Committee for review.
2. If an application is incomplete, staff will ask the applicant to provide the missing information within sixty (60) days. If the information is not received within sixty (60) days, the application will be suspended and reactivated only after all information is received. Incomplete applications cannot be forwarded to the Credentialing Committee for review and consideration.
3. During the processing of applications, applicants will be kept informed of the status of their applications as required.
4. Primary Source Verification is performed in strict adherence to NCQA guidelines, including query of the National Practitioner Data Bank (NPDB) utilizing MCO identifier.
5. Qualified staff will perform site visits, periodic review and validation of primary source data for recredentialing.
6. The Chief Medical Officer will monitor the quality and timeliness of the primary source verification activities, and its activities will be reported to the Credentialing Committee, and to the Quality Management and Improvement Committee at least yearly.

Primary Source Verification - Concealment

1. The Chief Medical Officer will implement the following procedure whenever one or more of the declarations that make up the signed attestation are not corroborated by the Primary Source Verification:
 - a) The Chief Medical Officer will send a letter to the applicant which points out the specific sections of the attestation that are not corroborated by the Primary Source Verification.

- b) The applicant is asked to fill out and sign a blank attestation that is included.
 - c) If, in response to the above letter, the applicant returns a signed attestation which is corroborated by the Primary Source Verification, then the application will proceed through the usual channels.
 - d) If, in response to the above letter, the applicant returns a signed attestation which is not corroborated by the Primary Source Verification, or there is evidence of deliberate concealment of relevant information, then the Chief Medical Officer will deny the application.
2. The Credentialing Committee has complete discretion in reviewing applications. In reviewing an application, the Committee may request further information from the applicant. The Credentialing Committee may table an application pending the outcome of an investigation of the applicant by a hospital, licensing board, government agency or any other organization or institution, or may recommend any other action it deems appropriate.
 3. The Credentialing Committee has the discretion to base its action on any factors it deems appropriate, whether or not these factors are mentioned in the credentialing plan.
 4. In the event of denial, or recommendation for approval with restriction, the applicant may appeal to the Quality Management and Improvement Committee through the Chief Medical Officer for further consideration. A request for appeal must be made in writing and within thirty (30) days of the date the Credentialing Committee gave notice of its decision to the applicant.

Appeals Procedure

1. Upon receipt of a provider's written appeal request, the Chief Medical Officer will notify the provider that an appeal hearing will be scheduled before the Credentialing Committee, and that the Credentialing Committee will provide further information when a hearing date is set. For the appeal to occur before the denial is final, the hearing must occur not less than thirty (30) and not more than ninety (90) days from the day the provider is given notice, unless the parties mutually agree upon a shorter period.
2. When a hearing is scheduled, the Credentialing Committee will provide a written hearing notice to the provider stating the time and place of the hearing, and advise the provider that he/she may present any evidence he/she wishes to the Credentialing Committee at the hearing.

Delegated Credentialing

1. Credentialing and recredentialing activities may be delegated to entities requesting delegation only when there is documented evidence that such entities meet ASES credentialing standards.
2. The MCO and ASES will use a formal, systematic process to monitor delegated credentialing and recredentialing activities prior to initial delegation and annually thereafter.
3. Both parties MCO and ASES (and the delegated entity) will mutually agree upon a Letter of Agreement for Delegated Credentialing Activities.
4. The Letter of Agreement will contain at least the following information:
 - a) Responsibilities of both parties
 - b) Delegated activities
 - c) Frequency of reporting
 - d) Process for evaluating the delegate's performance
 - e) Remedies if the delegated entity does not perform according to established standards
5. As part of the oversight process, ASES will review, make recommendations (as necessary) and approve the delegated entity's credentialing related policies and procedures, provided they meet the requirements of ASES Credentialing Plan.

6. A formal on-site audit of the delegate's credentialing program will be conducted and documented, including an audit of credentialing and recredentialing files. The audit results will be presented in a report. At a minimum, 5% or 50 practitioner files, whichever is less, will be audited.
7. An exception will be made for smaller delegated entities with fewer than 10 physicians who have been initially credentialed or recredentialed in any given year. In such a case, all initially credentialed or recredentialed physicians will be audited.
8. The MCO and ASES will notify the delegate of the results of the audit and will outline areas of deficiency if any exists.
9. Results of the audit and a corrective action plan submitted by the delegate (if applicable), will be presented to ASES and the MCO Credentialing Committee for review and action.
10. The delegate is required to submit the names of all newly credentialed and recredentialed physicians to ASES and the MCO on a monthly basis (or on the approved schedule that the delegate follows for credentialing).
11. The list of physicians received from the delegate will be forwarded to the Credentialing Committee which retains the right to approve, suspend or terminate physicians.

Discipline of Providers

1. The Credentialing Committee will recommend discipline of a participating provider for substandard performance, or failure to comply with administrative requirements as set out in this plan. Consideration of disciplinary action may be initiated by any information the Committee deems appropriate.
2. In making recommendations, the Committee will consider quality of care, financial, organizational or any other factors it deems relevant. Examples of disciplinary actions include, but are not limited to, the following:
 - a. Require the provider to submit and adhere to a corrective action plan;
 - b. Monitor the provider for a specified period of time, followed by a Committee determination as to whether substandard performance or noncompliance is continuing;
 - c. require the provider to use medical or surgical consultation for specified types of care;

- d. Require the provider to obtain training in specified types of care;
- e. Cease enrolling new members under the care of the provider;
- f. Temporarily suspend the provider's participation status;
- g. Declare the provider ineligible for the receipt of physician contingency reserves or other incentive payments;
- h. Terminate the provider's participation status.
- i. The Chief Medical Officer may determine at his/her sole discretion that the health of any MCO member is in imminent danger because of the actions or inaction's of a participating provider, and in such a case the Chief Medical Officer may immediately suspend or restrict the provider's participation status, during (under review)
- j. which time the Credentialing Committee will investigate to determine if further action is required.

Termination of Providers

1. The Chief Medical Officer may immediately suspend or restrict a provider's participation status upon learning of adverse license action or exclusions from Medicare and/or Medicaid .h).
2. The Credentialing Committee may recommend termination of the participation of a provider. Consideration of termination may be initiated by any information the Committee deems appropriate including but not limited to the following:
 - a. The provider fails to meet one or more of the administrative requirements or professional criteria as outlined in this plan;
 - b. The provider rendered (s) care to members in a harmful, potentially harmful, personally offensive, unnecessary, or inefficient manner.
 - c. The provider fails to provide access to care to an extent that continuity of care provided to enrolled patients is inadequate.

- d. The provider engaged (s) in abusive or fraudulent billing practices, including but not limited to submitting claims for payment that were false, incorrect or duplicated.
 - e. The provider fails to comply with the credentialing entity policies and/or procedures, including those for utilization management, quality assessment or billing.
 - f. The provider's privileges at a network institution or any other institution are lost or restricted for any reason.
 - g. The provider's license or DEA certificate are limited, suspended or revoked by any agency authorized to discipline providers.
 - h. The provider is censured, suspended or disqualified as a Medicare or Medicaid provider.
 - i. The provider is indicted or convicted of a felony.
 - j. The provider fails to comply with the application, selection or recredentialing process, or submits false, incomplete or misleading information with respect to credentials.
 - k. The provider fails to comply with any provision of the provider agreement.
 - l. The provider renders professional services outside the scope of his/her license, or beyond the bounds of appropriate authorization.
 - m. The provider fails to maintain malpractice insurance that meets approved guidelines.
 - n. The provider experiences physical or mental impairment, including chemical dependency, which affects his/her ability to provide care to patients, or fails to meet the criteria of the Plan's provider impairment policy, or the relevant policies of network institutions.
3. All appropriate authorities will be notified of termination and suspension from the the MCO Network.

4. The MCO will not discriminate against any health care professional in terms of participation, reimbursement or indemnification who is acting within the scope of his/her license.

Procedure for Discipline or Termination

1. If the Credentialing Committee receives information which it believes suggests that the discipline or termination of a provider may be warranted for reasons relating to the provider's professional competence, character or conduct, it will request the Chief Medical Officer or Credentialing Manager to investigate the matter.
2. If the Credentialing Committee believes that further information is needed, it may obtain it from the provider or other sources. The Committee may request or permit the provider to appear before the Credentialing Committee to discuss any issues relevant to the investigation.
3. In the event that the Committee's recommendation is to impose any disciplinary action, including but not limited to termination of the provider, the committee shall provide to the provider a written explanation of the reasons and notice of the opportunity for review and/or hearing. Such review shall take place prior to submission of the recommendation to the Board and implementation of any disciplinary action, unless the reasons involve imminent harm to patients, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the provider's ability to practice. In these cases the Credentialing Committee may immediately suspend or restrict the provider's participation in the network.
4. Subject to the provider's rights to appeal, The Credentialing Committee's recommendations will be forwarded to the Quality Management and Improvement Committee for final approval.

Review Procedure

1. The Credentialing Committee shall notify the provider that he or she has a right to request a hearing or review of said recommendation. The notice shall include the following:
 - a. The reasons for the proposed action.
 - b. That the provider has the right to request a hearing or review before a panel appointed by the Chief Medical Officer.
 - c. That the provider must submit to the Chief Medical Officer a written request for a hearing and/or review within thirty (30) days of receipt of the notice of proposed disciplinary action and right to review.

- d. That a hearing must be held within thirty (30) days of the Chief Medical Officer's receipt of a request for hearing.
- e. Upon receipt of a request for hearing or review, the Chief Medical Officer shall inform the Quality Management and Improvement Committee. The QMIC shall then select a review panel consisting of three (3) persons, the majority of whom are clinical peers in the same discipline and same or similar specialty as the provider under review, and none of whom are members of the Credentialing Committee. The QMIC may appoint more than three (3) persons to the Review Panel provided that at least one third of its members are clinical peers of the provider under review. The QMIC shall appoint one of the Review Panel members as Chairperson.
- f. Within seven (7) days of receipt of a provider's written request for hearing, the Chief Medical Officer will notify the provider of the time and place of the hearing, which shall be no more than thirty (30) days after receipt by the Chief Medical Officer of the request for hearing, unless the parties mutually agree upon a later date. In addition, said notice shall include the witnesses, if any, to be called by the Credentialing Committee in support of its recommendation, and a list of the members of the Review Panel.

The Hearing

1. Ordinarily, the Credentialing Committee will be represented by its Chairman during the appeal process. However, the provider and the Credentialing Committee may be represented by counsel or another person of their choice.
2. The Credentialing Committee will be responsible for the recording of the hearing. The following procedure will then be followed:
 - a. Chairman's Statement of the Procedure: Before evidence or testimony is presented, the Chairman of the Review Panel will announce the purpose of the hearing and the procedure that will be followed for the presentation of evidence.
 - b. Presentation of Evidence by Credentialing Committee: The Credentialing Committee may present any oral testimony or written evidence it wants the Review Panel to consider. The provider or the provider's representative will have the opportunity to cross-examine any witness testifying on the Credentialing Committee's behalf.

- c. **Presentation of Evidence by Provider:** After the Credentialing Committee submits evidence, the provider may present evidence to rebut or explain the situation or events described by the Credentialing Committee. The Credentialing Committee will have the opportunity to cross-examine any witnesses testifying on the provider's behalf.
- d. **Credentialing Committee Rebuttal:** The Credentialing Committee may present additional written evidence to rebut the provider's evidence. The provider will have the opportunity to cross-examine any additional witnesses testifying on the Credentialing Committee's behalf.
- e. **Summary Statements:** After the parties have submitted their evidence, the Credentialing Committee and then the provider will have the opportunity to make a brief closing statement. In addition, the parties will have the opportunity to submit written statements to the Review Panel. The Review Panel will establish a reasonable time frame for the submission of such statements. Each party submitting a written statement must provide a copy of the statement to the other party.
- f. **Examination by Review Panel:** Throughout the hearing, the Review Panel may question any witness who testifies.

Evidentiary Standards

1. The evidence must reasonably relate to the specific issues or matters involved in the recommended action. The Review Panel has the right to refuse to consider evidence that it deems irrelevant or otherwise unnecessary to consider.
2. An individual who objects to the presentation of any evidence must state the grounds for the objection and the Review Panel has the sole discretion to determine whether the evidence will be admitted.

Review Panel Determination

1. The Review Panel may, at its sole discretion, uphold, reject or modify the recommendation of the Credentialing Committee. The decision of the Review Panel will be based upon the affirmative vote of a majority of the Review Panel members.
2. The Review Panel's decision may include (i) reinstatement of the provider; (ii) provisional reinstatement subject to conditions set forth by the Review Panel; or (iii) termination of some or all privileges of participation in the Plan. The Chairperson of the

Review Panel will notify the provider in writing within 10 business days of the decision and the basis therefore.

3. If a provider is terminated or his or her privileges are curtailed, the Credentialing Committee will ensure that patients or clients of the plan who have or are currently obtaining services from the provider are notified and that access to alternative providers within the Plan is made available to them.

Three Year Recredentialing Cycle

1. In order to ensure ongoing compliance with all eligibility criteria, every provider will be subject to recredentialing every three years.
2. Applicants who were expected to complete board certification prior to the recredentialing date will be required to provide documentation of certification.
3. The participating providers will be sent a questionnaire requesting updated answers to many of the questions that appear on the original application. The completed questionnaire must be returned within the time frames established by the Credentialing Committee.
4. The required supporting documents will be the same as those originally required. In addition to the questionnaire, the Committee may consider in the recredentialing process any information it has available regarding the following. (including, but not limited to the following)
 - a. Member complaints
 - b. Quality of services
 - c. Utilization management (Compliance with protocols, standards and procedures)
 - d. Member satisfaction (access, availability and waiting time)
 - e. Medical records
 - f. Result of office site visits
 - g. Disciplinary actions, including Medicare and Medicaid sanctions

- h. Current list of hospitals where provider has privileges
 - i. Physician profile
 - j. Ongoing validation of primary source documentation will be performed by the staff of the MCO.
 - k. Ongoing Monitoring of Sanctions and Complaints
 - l. Sanctions
5. Between recredentialing cycles information on adverse license actions and exclusions from Medicare and/or Medicaid is obtained from the appropriate government licensing/professional conduct agencies. .
 6. The Credentialing staff reviews information on the date it is received by the MCO.
 7. If a Medicare sanctioned or excluded provider is identified as a participating provider, the Credentialing Coordinator or his/her designee will obtain the complete order and present it to the Chief Medical Officer for his/her action.

Complaints

1. Any complaints about a participating physician received by the Plan will be referred to the Chief Medical Officer and will be investigated within 30 days. The Chief Medical Officer will determine what action needs to occur.
2. All complaints are subsequently forwarded to the Medical Management Committee for review, which meets quarterly.

Amendments to the Credentialing Plan

1. The Credentialing Plan may be updated and amended from time to time by authority of the Quality Management and Improvement Committee.
2. Such amendments may include changes in criteria of eligibility based on the changing needs of the managed care organization, etc.

3. This plan will be evaluated by the Credentialing Committee yearly and submitted to the Credentialing Committee and Quality Management and Improvement Committee for approval.

Subcontractor/Vendor Oversight

1. The MCO will request and review all subcontractor and vendor Credentialing Plans and Provider materials to ensure that they have written policies and procedures for participation, including a process for adverse participation decisions that is consistent with CMS and ASES requirements and the MCO policies and procedures.

****Currently under review****