



2010 UHSMC Credentialing Program Description Effective: February 1, 2010

Annually, the following oversight committees shall approve this document:

- **The Virginia Premier Health Plan and Carolina Crescent Health Plan Credentialing Committees**
- **The Continuous Quality Improvement Committee (CQIC)**
- **The University Health Systems Managed Care (UHSMC) Board of Directors**

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I. Definitions:

The acronyms, phrases, words and terms used in this document shall have the following meanings unless the context specifically states otherwise:

1. **Ambulatory Surgical Center (ASC):** Medicare defines ASCs as a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients. ASCs must be certified as meeting the requirements for an ASC and must enter into a participating provider agreement with the Centers for Medicare & Medicaid Services (CMS). An ASC can either be:
 - A. Independent (not part of a provider of services or any other facility)
 - B. Operated by a hospital (under the common ownership, licensure, or control of a hospital). To be covered as an ASC operated by a hospital, the facility:
 - o Elects the coverage and is covered as such unless CMS determines that there is good cause to do otherwise
 - o Is a separately identifiable entity that is physically, administratively, and financially independent and distinct from other operations of the hospital, with costs for the ASC treated as a nonreimbursable cost center on the hospital's cost report
 - o Meets all requirements regarding health and safety and agrees to the assignment, coverage, and payment rules applied to independent ASCs
 - o Is surveyed and approved as complying with the conditions for coverage for ASCs
2. **Board:** The Board of Directors of University Health Systems Managed Care (UHSMC); UHSMC Board of Directors (the "Board") has ultimate authority, accountability and responsibility for the Credentialing evaluation process (the "Credentialing Program"); the Board has delegated full oversight of the Credentialing Program to the Credentialing Committee; the Board is comprised of top executives, including legal counsel, employed by the Virginia Commonwealth University Health System, which owns UHSMC; community practitioner(s), the CEO of UHSMC, Senior Medical Director, Vice President of Medical Management, Vice President of Quality, Credentialing and Accreditation and other UHSMC executives attend the Board meetings, as required.
3. **CAQH:** Council for Affordable Quality Healthcare; Manages the Universal Credentialing Initiative by which a practitioner can submit a single application to one central database to meet the needs of all of the health plans and Networks participating in the CAQH effort. Practitioners may easily update their information online or via fax anytime, and will confirm once each quarter that the data on file is complete and accurate. CAQH is a coalition of more than 20 of America's largest health plans and Networks and three principal health plan associations working together to help improve the healthcare experience for consumers and physicians. There is no cost for CAQH participation for the practitioners. The health plans pay a cost to access the information.
4. **Clean Practitioner or Provider:** A practitioner or provider who meets the standards, guidelines, and/or criteria for network participation

5. **CMS: Centers for Medicare and Medicaid Services headquartered in Baltimore, MD; Under the direction and oversight of the U.S. Department of Health and Human Services; Social Security Act, Titles 18, 19 and 21.**
6. **CQIC:** Continuous Quality Improvement Committee; Committee of UHSMC that is comprised of the executive leadership team. Although credentialing decisions are not made to this committee, decisions may be reported.
7. **Credentialing Process:** Includes, for the purposes of this document, both the credentialing and recredentialing of independently licensed practitioners and/or organizational providers; initial credentialing is conducted prior to a practitioner or provider being presented to the Credentialing Committee for approval; recredentialing is conducted within three (3) years of the initial credentialing process.
8. **Delegated Credentialing:** Occurs when the credentialing functions of a managed care organization or other organization have been outsourced or contracted out to be performed by another capable organization.
9. **DMAS:** The Department of Medical Assistance Services, in the Commonwealth of Virginia; an agency of the Commonwealth of Virginia regulated pursuant to the Social Security Act 19.
10. **DHHS:** The Department of Health and Human Services in the State of South Carolina
11. **Dual Credentialing:** A practitioner (typically an internal medicine practitioner) or provider who is educated and medically trained to provide medical care in two specialties (i.e., internal medicine and gastroenterology, etc.)
12. **Dual Contracting:** A practitioner that is contracted directly with UHSMC and also with a contracted delegated entity.
13. **High-Volume:** Fifty (50) or more members on a participating practitioner's or provider's panel.
14. **Independent relationship:** Exists when the organization selects and directs its members to see a specific practitioner, provider or group of practitioners or providers, including all practitioners or providers whom members can select as primary care practitioners (PCP).
15. **Licensed independent practitioner or provider (LIP):** A practitioner or provider who does not work under the auspices or authority of another practitioner or provider.
16. **Locum Tenens:** A Latin phrase that means "to hold the place of, to substitute for," In layman's terms, it means a temporary and/or covering practitioner.
17. **MA Plan:** Medicare Advantage Plan; alternative (to the traditional Medicare fee-for-service program) healthcare delivery system for eligible Medicare beneficiaries.
18. **Medical Directors:** UHSMC's staff of Medical Director(s); employed Medical Directors include:
 - A. **Chief Medical Officer (CMO):**
 - B. **Senior Medical Director:** The Senior Medical Director is responsible for providing direction for the development and implementation of the Credentialing, Quality Improvement, Utilization Management and New Technology, and other Medical Management programs; the Senior Medical Director is responsible for peer review activities and the collaboration with Practitioners on the development and

implementation of the Credentialing Program and is Chairman of the Credentialing Committee; classified as an administrative medical director.

- C. **Associate Medical Director:** The Associate Medical Director reports to the Senior Medical Director and assists the Senior Medical Director in carrying out all responsibilities, as required. “Administrative Medical Director” – UHSMC’s Staff Medical Director who is not required to be credentialed because s/he does not provide direct office based, and/or hospital care to UHSMC members. The Medical Director’s license and malpractice shall be verified to ensure they are unrestricted, current and/or valid, and shall be included in the Human Resources File. Board Certification is not required, although preferred. In the event the Medical Director participates in a University or other teaching program advising others, the unique teaching program will assume any further credentialing request.
- o “Non-Administrative Medical Director” – UHSMC’s Staff Medical Director who is required to be credentialed by UHSMC because s/he performs patient care duties and/or provides office/hospital care to the members of the Plan. The practitioner also has hospital privileges.
19. **Member:** An individual residing in the Commonwealth of Virginia or the state of South Carolina and eligible for UHSMC services.
20. **Nationally Recognized Accrediting Entity/Body:** An organization that sets national standards specifically governing healthcare quality assurance processes, utilization review, practitioner credentialing, as well as other areas covered in this document and provides accreditation to managed care health insurance plans pursuant to national standards. The following entities are examples of nationally recognized accrediting entities/bodies:
21. **URAC:** Utilization Review Accreditation Commission (URAC)
22. **JCAHO:** Joint Commission on Accreditation of Healthcare Organizations
23. **NCQA:** National Committee for Quality Assurance; an accrediting body overseeing a variety of health plan functions and ensures quality.
24. **Network Practitioner:** Accredited and/or verified person who has entered into a contractual agreement with UHSMC to provide healthcare services to its members and follow all established plan policies and procedures.
25. **Organizational Providers:** Medical Organizational providers include: hospitals home health agencies including infusion services providers, durable medical equipment companies, skilled nursing facilities, free standing surgical centers (of any type – gynecology and/or obstetrics - birthing centers, ophthalmology – laser surgery centers, urological surgery centers, dental surgery centers, cardiac surgery centers, orthopedic surgery centers, free standing hospice centers and rehabilitation facilities; behavioral health organizational providers include: Inpatient, residential, and ambulatory; Please note: By listing all types of organizational providers in no way imply that all said providers referenced are covered under UHSMC benefit structure.
26. **Office of the Inspector General (OIG):** The Health and Human Services Office of Inspector General is responsible for excluding individuals and maintaining a sanctions list that identifies those practitioners and providers who have participated or engaged in certain impermissible, inappropriate, or illegal conduct to include, but not limited to fraudulent billing and misrepresentation of credentials. The OIG’s List of Excluded Individuals and Entities (LEIE) provides

information on all individuals and entities currently excluded from participation in the Medicare, Medicaid, and all other Federal health care programs.

If identified billing practices are suspected to be potentially fraudulent or abusive, the **OIG's National Hotline** should be contacted at **1-800-HHS-TIPS (1-800-447-8477)** to report the activity.

Contacting the HHS OIG Hotline:

By Phone: 1-800-HHS-TIPS (1-800-447-8477)

By Fax: 1-800-223-8164

By E-Mail: HHSTips@oig.hhs.gov

By TTY: 1-800-377-4950

By Mail:

Office of Inspector General

Department of Health and Human Services

Attn: HOTLINE

330 Independence Ave., SW

Washington, DC 20201

Centers for Medicare & Medicaid Services (CMS): Suspicions of fraud or abuse may also be reported to Medicare's Customer Service Center at **1-800-MEDICARE (1-800-633-4227)**.

27. **Primary Source Verification:** The original source of a specific credential that can verify the accuracy of a qualification reported by an individual health care practitioner/provider. Examples include medical school, graduate medical education program, and state medical board.
28. **URAC:** Utilization Review Accreditation Commission; an accrediting body overseeing a variety of health plan functions and ensures quality.
29. **VPHP:** Virginia Premier Health Plan, Inc.; a wholly owned, for-profit, subsidiary of Virginia Commonwealth University Health Systems; Medicaid product line of business.
30. **CCHP:** Carolina Crescent Health Plan, Inc.; a wholly owned, not-for-profit, subsidiary of Virginia Commonwealth University Health Systems; Medicaid product line of business.

II. AUTHORITY AND RESPONSIBILITY FOR CREDENTIALING

UHSMC Board of Directors (“Board”) has ultimate authority, accountability and responsibility for the Credentialing evaluation process (“Credentialing Program”). The Board has delegated full oversight of the Credentialing Program to the Credentialing Committee (“Committee”). The Credentialing Committee accepts the responsibility of administering the Credentialing Program and having oversight of operational activities, which include making the final decision, (i.e., approve, table, and deny) on all practitioners and providers, regarding participation in the network. At least annually, a report will be presented, for review, to the Credentialing Committee, Continuous Quality Improvement Committee (CQIC), and/or the Board, via the Quality Improvement Annual Evaluation or other comparable report, as deemed appropriate.

(See Credentialing Structure and Governance Organizational Chart - Attachment 1).

III. PURPOSE

The Credentialing Program of University Health Systems Managed Care (UHSMC) shall be comprehensive to ensure that its practitioners and providers meet the standards of professional licensure and certification. The process enables UHSMC to recruit and retain a quality network of practitioners and providers to serve its members and ensure ongoing access to care. It consistently and periodically assesses and evaluates a practitioner's or provider's ability to deliver quality care between credentialing and recredentialing cycles, and it emphasizes and supports a practitioner's and provider's ability to successfully manage the health care of network members in a cost-effective manner.

The Credentialing Program enables UHSMC to ensure that all practitioners and providers are continuously in compliance with the Centers for Medicare and Medicaid Services (CMS) requirements, the Department of Medical Assistance Services (DMAS) or designee requirements, the National Committee for Quality Assurance (NCQA) standards, the Utilization Review Accreditation Commission (URAC) standards, UHSMC policies and procedures, and any other applicable regulatory or accreditation entity's requirements and/or standards.

The UHSMC Credentialing and Recredentialing standards, contained in this official guidance document, for types of practitioners and providers shall be reviewed by clinical peers, as required, that are members of the UHSMC Credentialing Committee. The process of peer review is established, evidenced in this document, when considering employing or contracting with a practitioner or provider who does not meet UHSMC's established credentialing standards.

IV. CREDENTIALING COMMITTEE STRUCTURE & ACTIVITIES

A. Composition:

The Senior Medical Director is responsible for the oversight and operation of the Credentialing Program and serves as Chairperson or may appoint a Chairperson, with equal qualifications. The Chief Medical Officer and Chairman, CEO of UHSMC, the UHSMC Board Chairman, must review and approve, by signing and dating, the Annual Credentialing Program each year.

The Committee is a physician, peer-review body that includes participating practitioners, spanning a range of specialties, including primary care (i.e., family practice, internal medicine, pediatrics, general medicine, obstetrics/gynecology, geriatrics, etc.) and specialty care to include, but not limited to, behavioral health. In the event of a practitioner appeal and/or review of an adverse action, an ad-hoc committee member will be appointed by the Chief Medical Officer who will represent the specialty of the specialty of the appealing practitioner if that specialty is not already represented. Allied health representatives specializing in rehabilitation therapy (physical, occupational, speech, language), audiology, orthotics, prosthetics, social work, non-physician mental health (psychologist) therapy, etc. may be appointed to serve as non-voting members, on an ad hoc basis. Members may be appointed as members, rotated or removed from the Committee at the sole discretion of the Senior Medical Director.

B. Responsibilities/Duties:

The Committee shall be responsible for the credentialing process of all independently licensed practitioners. Its purpose is to monitor all credentialing activities and delegated credentialing arrangements, to include, but not be limited to:

- o Receive and review the credentials of all practitioners being credentialed or recredentialed who do not meet the organization's established criteria, and to offer advice, which the organization considers. This includes evaluating practitioner files that have been identified as problematic (e.g. malpractice cases, licensure issues, quality concerns, missing documentation, etc.)
- o Review practitioner credentials and give thoughtful consideration to the credentialing elements before making recommendations about a practitioner's ability to deliver care.
- o Establish, implement, monitor, and revise policies and procedures for UHSMC credentialing and recredentialing
- o Report to the CQIC, Board and other appropriate authorities, as required
- o Annual Review of the Credentialing Program Description
- o Other related responsibilities

The Senior Medical Director or his/her designee may review and sign off on a list of the names of clean practitioners and providers who meet the established criteria before, between, and after each Committee meeting.

Clean practitioners may be voted upon prior to a scheduled face-to-face Committee Meeting. At the next scheduled Committee Meeting, these approved practitioners will be presented to ensure network participation decisions are recorded in the meeting minutes.

C. Quorum:

A quorum (majority of voting members present) shall be satisfactory for the valid transaction of business by the Committee, which meets at least monthly and/or as deemed necessary by the Chairperson. The Committee action may be implemented in the absence of a face-to-face or other type meeting if consent in writing, setting forth the action, is obtained. Voting members include only the Committee Physicians and the Vice President of Network Development or his/her designee. Non-voting members include the Credentialing Manager, the Vice President of Quality, Accreditation and Credentialing, the Vice President of Medical Management and/or other Plan representatives.

D. Minutes and Reports:

Complete and accurate minutes will be prepared and maintained for each meeting. Minutes will reflect the name of the Committee, the date and duration of the meeting, the members present and absent, and the names of guests or other representatives. The minutes will reflect decisions and recommendations, the status of activities in progress, and the implementation status of recommendations, when appropriate. Applicable reports and substantiating data will be appended for reporting purposes. The Committee will be responsible for reviewing minutes for their accuracy. Minutes shall be securely retained electronically and manually.

E. Confidentiality Policy:

It is the policy and procedure of UHSMC to consider all credentialing documents received from the practitioner, verification sources for the purposes of credentialing and subsequently retained as a result of the credentialing process as confidential. The mechanisms, in effect, to ensure the confidentiality of information collected in this process are as follows:

- o Access to such documents will be restricted to: (1) The practitioner or provider being credentialed, pursuant to the requirements outlined in this document below titled "Erroneous, Incomplete or Illegible Information," (2) Committee Members, (3) Board Members, (4) UHSMC Credentialing Staff, and (5) Other specific individuals as designated by the Board and/or UHSMC's CQIC.
- o The limited number of staff, with access to the credentialing database, is required to have individual user names and passcodes to access credentialing related information.
- o Credentialing materials, all of which are contained within the Medical Management Department, are secured via a passcode protected door in which entry must be gained.

F. Conflict of Interest:

No person may participate in the review and evaluation of any professional practitioner or provider, as applicable, with whom s/he has been in a group practice, professional corporation, partnership, corporation, limited liability company or similar entity whose primary activity is the practice of medicine or where judgment may be compromised, as determined by the Credentialing Committee. The Chairperson of the Credentialing Committee shall have the authority to excuse a voting member from the Credentialing Committee in the presence of a conflict of interest.

V. THE CREDENTIALING PROGRAM: PRACTITIONERS

Scope of Credentialing:

The scope of the Credentialing Program is comprehensive and includes all practitioners that have an unrestricted, current and valid license and a National Provider Identification (NPI) Number. All licensed practitioners and groups of practitioners who provide care to UHSMC members are credentialed. Practitioners who are certified or registered by the state to practice independently and provide care to UHSMC members are also credentialed.

Nurse practitioners and physician assistants may participate in the network under the credentials of a supervising, participating physician if s/he has a National Provider Identification (NPI) Number.

A. Practitioners who will be credentialed and reviewed on an ongoing monitoring basis include:

- ❑ Practitioners who have an independent relationship with UHSMC or an inpatient setting. An independent relationship exists when UHSMC selects and directs its members to see a specific practitioner or group of practitioners, including all practitioners members can select as primary care practitioners. An independent relationship is not synonymous with an independent contract. NCQA does not require the organization to credential some practitioners with whom it holds independent contracts.
- ❑ Practitioners who see members outside the inpatient hospital setting or outside freestanding, ambulatory facilities.
- ❑ Dentists who provide care under UHSMC's medical benefits.
- ❑ Nonphysician practitioners who have an independent relationship with UHSMC, as defined above, and who provide care under the organization's medical benefits.
- ❑ Hospital based practitioners who have an independent relationship with UHSMC and an inpatient setting:
 - Anesthesiologists with pain-management practices
 - Cardiologists
 - University faculty who are hospital based and who also have private practices
- ❑ Dentists providing care under medical benefits:
 - Endodontists
 - Oral surgeons
 - Periodontists
- ❑ Non-physician practitioners who may have an independent relationship with UHSMC and provide care under UHSMC's medical benefits:
 - Behavioral health practitioners
 - Nurse practitioners
 - Nurse midwives
 - Physician assistants
 - Optometrists
 - Physical therapists

- o Occupational therapists
- o Speech and language therapists

B. Types of practitioners credentialed and audited (internally) during the year to ensure ongoing compliance:

- Medical practitioners:
 - o Medical doctors (MD)
 - o Dentists (DDS/DMD)
 - o Chiropractors (DC) – only applicable to FAMIS Members under the Medicaid line of business
 - o Osteopaths (DO)
 - o Podiatrists (DPM)

- Behavioral health practitioners:
 - o Psychiatrists and other physicians
 - o Addiction medicine specialists
 - o Doctoral or master's-level psychologists who are state certified or licensed
 - o Master's-level clinical social workers who are state certified or licensed
 - o Master's-level clinical nurse specialists or psychiatric nurse practitioners who are nationally or state certified or licensed
 - o Other behavioral healthcare specialists who are licensed, certified or registered by the state to practice independently

Additional types of practitioners, not listed above, may also be credentialed and subject to the same policies and procedures, as those listed in this document, to ensure ongoing quality for the UHSMC members. However, internal files reviews may be restricted to the practitioners listed above.

C. Practitioners who do not need to be credentialed:

- Practitioners who practice exclusively within free-standing facilities and who provide care for UHSMC members only as a result of members being directed to the facility
- Dentists who provide primary dental care only under a dental plan or rider
- Pharmacists who work for a pharmacy benefits management (PBM) organization to which UHSMC delegates utilization management (UM) functions
- Covering practitioners (e.g., locum tenens)
- Practitioners who do not provide care for members in a treatment setting (e.g., board-certified consultants)

- Practitioners who practice exclusively within the inpatient setting and provide care for UHSMC members only as a result of members being directed to the hospital or another inpatient setting:
 - o Pathologists
 - o Radiologists
 - o Anesthesiologists
 - o Neonatologists

- o Emergency room physicians
- o Hospitalists
- o Telemedicine consultants
- Practitioners who practice exclusively within free-standing facilities in which practitioners may practice exclusively and provide care for UHSMC members only as a result of members being directed to the facility:
 - o Mammography centers
 - o Urgent-care centers
 - o Surgicenters
 - o Ambulatory behavioral healthcare facilities
- Practitioners who practice exclusively within Ambulatory behavioral health care facilities:
 - o Psychiatric and addiction disorder clinics

VI. STANDARDS OF PARTICIPATION: PRACTITIONERS

A. Professional Criteria:

UHSMC accepts professional practitioners into its network at its sole discretion based on the need for professional practitioners in certain specialties, geographic areas, or similar considerations.

Each professional practitioner must meet minimum standards for participation in UHSMC's Network. These guidelines are intended to comply with plan, regulatory and accreditation standards established by CMS, DMAS, DHHS or its designee, NCQA, VPHP, CCHP, UHSMC, other applicable regulatory and/or accreditation entities and the laws of the Commonwealth of Virginia or the state of South Carolina, where applicable.

B. Minimum Standards for Participation include:

- ❑ Unrestricted (no limitations), current and valid professional licensure to practice in Virginia.
- ❑ Current and valid Federal DEA Certificate for practitioners with the authority to write prescriptions, as applicable for practice. When a practitioner waives his/her prescriptive authority, the DEA Form must be completed. **(See ATTACHMENT 2: DEA FORM)**
- ❑ Preferred Board certification in a recognized practice specialty. In lieu of Board Certification, the practitioner must have relevant education (Residency) in his/her practicing specialty. New graduates must become board-certified within five (5) years of completing an approved residency or fellowship-training program in their practice area. Board certification requirements may be waived upon review of the Credentialing Committee if the practitioner has five (5) years of verified relevant work history and/or has unrestricted, current active privileges in the specialty area at a participating hospital preferably in their respective service area.
- ❑ Current, unrestricted clinical privileges at a participating hospital, if applicable, or evidence of coverage/transfer arrangement with a privileged participating practitioner.
- ❑ Acceptable twenty-four (24) hour coverage system. Coverage system should include twenty-four (24) hour telephone coverage and arrangements for alternate care of patients in case of absence, through another professional practitioner that is consistent with UHSMC and/or payor's policies, procedures, standards and/or criteria.
- ❑ Acceptable, current and valid malpractice insurance in the amount \$1 Million per incident and \$3 Million per aggregate per year or as determined satisfactory by the Credentialing Committee. Current
- ❑ professional liability insurance coverage in a minimum amount equal to the amounts as in effect under § 8.01-581.15 - Limitation on recovery in certain medical malpractice actions is preferred.

- ❑ Absence of a history of denial or cancellation of professional liability insurance, involvement in malpractice suits, arbitration or settlement or evidence that the history does not suggest an ongoing substandard professional competence or conduct.
- ❑ Absence of health problems including drug or alcohol abuse, which might adversely affect judgment or competence, so as to substantially impede the professional practitioner's ability to perform the essential functions of his/her practice/profession.
- ❑ Absence of a history of disciplinary action resulting in suspension, repeal, or limitation by a licensing board, professional society, health care organization, managed care organization, governmental health care program; or evidence that this history does not suggest an on-going substandard professional competence or conduct.
- ❑ Absence of a history of criminal/felony convictions or indictments, or evidence that this history does not suggest an effect on current professional competence or conduct. A conviction within the meaning of this section includes a plea or verdict of guilty or a conviction following a plea of nolo contendere.

C. Exclusion Criteria:

- ❑ UHSMC shall, upon obtaining information or receiving information from a verifiable and reliable source, exclude from participation, in UHSMC's Network, all practitioners that may fall in any of the following categories (references to the Act in this Section refer to the Social Security Act):
 - ❑ Entities, which could be excluded under § 1128(b)(8), as amended, of the Social Security Act are entities in which a person who is an officer, director, or agent or managing employee of the entity, or a person who has direct or indirect ownership or controlling interest of five (5) percent or more in the entity has been convicted of any of the following crimes:
 1. Program related crimes, i.e., any criminal offense related to the delivery of an item or service under any Medicare, Medicaid, or other State health care program (as provided in § 1128(a)(1) of the Act, as amended);
 2. Patient abuse, i.e., a criminal offense relating to abuse or neglect of a patient in connection with the delivery of a health care item or service (as provided in § 1128(a)(2) of the Act, as amended);
 3. Fraud, i.e., a State or Federal crime involving fraud, theft, embezzlement, breach of fiduciary

D. Quality of Practice Criteria:

- ❑ Professional practitioner(s) must demonstrate acceptable office site survey and medical record keeping practices, which meet CMS, DMAS or DHHS or its designee, NCQA, VPHP, CCHP, UHSMC or any other standards adopted by UHSMC.
- ❑ Professional practitioner(s) practice patterns must reflect a general adherence to established practice standards and protocols as adopted by UHSMC.

- Professional practitioner(s) must maintain satisfactory performance in the area of practice quality indicators (i.e., clinical outcomes, performance measure outcomes, member satisfaction, etc.) established by UHSMC.

E. Business Administrative Criteria:

- Professional practitioner(s) must maintain a practice site within the UHSMC access standard requirements at which the majority of the ambulatory services customarily provided might be rendered.
- Professional practitioner(s) area of specialty fills a network need as determined by UHSMC. UHSMC reserves the right to deny participation, on a case-by-case basis, if the need does not exist for a particular specialty and if such action is deemed in the best interest of the network.

VII. INITIAL CREDENTIALING: PRACTITIONERS

A. Process and Requirements:

UHSMC credentials all practitioners prior to being admitted into the UHSMC network. The intent of the process is to validate and/or confirm credentials information related to a prospective or participating practitioner by contacting the primary source of the issuing credential directly. All attestations and verification time limits, applicable in this Credentialing Program and referenced in this document, shall not exceed 180 calendar days of the Committee Meeting and/or Committee Decision.

Each practitioner must submit a legible and completed application, consent form that is signed and dated, a confidentiality form that is signed and dated, a signed and dated Master Agreement and all other required documentation. The following information is obtained and verified according to the standards and utilizing the sources listed under Initial Credentialing:

- ❑ Completed UHSMC or CAQH application, which includes a current and signed attestation and addresses. Application includes the following information:
 1. Reasons for inability to perform the essential functions of the position, with or without accommodation
 2. Lack of present illegal drug use
 3. History of loss of license and felony conviction
 4. History of loss or limitation of privileges or disciplinary actions
 5. Current malpractice insurance coverage
 6. The correctness and completeness of the application
- ❑ Copy of the unrestricted (no limitations), current and valid license or license number for the participating practitioner
- ❑ Copy of the current and valid DEA/CDS Certificate, if applicable
- ❑ Copy of the medical malpractice policy face sheet
- ❑ Copy of the board certificate or highest level of education; proof of education, training and competency
- ❑ Copy of the current Curriculum Vitae (CV), which must include work history (Gaps or interruptions in work history 6 months or greater must be explained; the CV, attached to the application, must include a work history covering at least 5 years and a statement by the applicant regarding: (1) Any limitations in ability to perform the functions of the position, with or without accommodation; (2) History of loss of license and/or felony convictions; and (3) History of loss or limitation of privileges or disciplinary activity).
- ❑ Quality measures (initial credentialing site visit and medical record keeping practices)
- ❑ Primary Source Verification of associated credentialing documentation
- ❑ The Credentialing Committee's final decision (the practitioner shall be notified, in writing, within 60 calendar days of the Committee's decision)

Practitioners may submit their applications and/or information to the Center for Affordable Quality Healthcare (CAQH). Upon notification from the prospective practitioner that his/her application is filed with CAQH, UHSMC's credentialing staff will promptly download the application to initiate the credentialing process.

B. Primary Source Verification:

The UHSMC credentialing staff will conduct primary source verification as required by the most current and applicable CMS, DMAS, DHHS or its designee, NCQA, UHSMC and other UHSMC adopted guidelines. UHSMC accepts letters, telephone calls, faxes, computer printouts, and/or online viewing of information as acceptable sources of verification with appropriate reference documentation (i.e., the name of the person who provided verification, the date of the call, and the verifier's name). The information must be accurate and current.

Verbal verifications documented in credentialing files are dated and signed by the credentialing staff member who receives the information-noting source and date. Written verifications are received in the form of letters or documented review of latest cumulative reports released by primary sources. Internet verifications may be obtained from any CMS, DMAS, DHHS or its designee, NCQA, and/or UHSMC-approved web-site source.

To meet verification standards, all credentials must be valid at the time of the Credentialing Committee's decision per Table VII-7(b) below and the specific time limits as set forth by CMS, DMAS or its designee, NCQA, URAC, UHSMC and any other applicable regulatory and/or accreditation entities:

Table VII-A:

Primary Source Information:	Acceptable Sources:
<input type="checkbox"/> Credential: License <input type="checkbox"/> Verification Time Limit: 180 cal days Must confirm that practitioners hold a valid, current state license or certification, which must be in effect at the time of the Committee's decision; must verify licenses or certification as applicable in each state where practitioners provide care for plan members; <u>verification must come directly from the state licensing or certification agency</u> ; if the plan uses the Internet to verify state licensure or certification, the Web site must be from the appropriate state licensing agency.	<input type="checkbox"/> State Agency
<input type="checkbox"/> Credential: DEA or CDS Certificate <input type="checkbox"/> Verification Time Limit: None for graduation from medical or professional	<input type="checkbox"/> A copy of the DEA or CDS certificate <input type="checkbox"/> Documented visual inspection

Primary Source Information:	Acceptable Sources:
<p>school and completion of residency.</p> <p>Must be effective at the time of the credentialing decision; must be verified in each state in which the practitioner cares for plan members.</p>	<p>of the original certificate</p> <ul style="list-style-type: none"> ❑ Confirmation with the DEA or CDS Agency ❑ Entry in the National Technical Information Service (NTIS) database ❑ Entry in the American Medical Association (AMA) Physician Master File Confirmation from the state pharmaceutical licensing agency where applicable
<ul style="list-style-type: none"> ❑ Credential: Education and Training Verification Time Limit: None for graduation from medical or professional school and/or completion of residency. <p>The organization must verify the highest of the three levels of education and training obtained by the practitioner.</p> <ol style="list-style-type: none"> 1. Graduation from medical or professional school 2. Residency, if appropriate 3. Board certification, if appropriate <p>Printout from state licensing agency's Web site: The plan may use a dated printout of the licensing agency's Web site in lieu of a letter or other written notice as long as the site states that the agency verifies education and training with primary sources and indicates that this information is current; NCQA does not require the plan to obtain written confirmation from the licensing board if there is a state statute that requires the licensing board to obtain verification of education and training directly from the institution; the plan must include a copy of the relevant state statute as proof</p> <p>Note: If a practitioner's education has not changed during the recredentialing cycle, the previous education verification will stand and not be re-verified.</p> <ul style="list-style-type: none"> ❑ Credential: Board Certification ❑ Verification Time Limit: 180 cal days 	<p>Graduation from medical school (MD, DO):</p> <ul style="list-style-type: none"> ❑ Medical School ❑ AMA Physician Master File American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA ❑ Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986. ❑ Association of schools of the health professional, if the association performs primary source verification. At least annually, the organization must obtain written confirmation from the association that it performs primary source verification. ❑ State licensing agency, if the state agency performs primary-source verification. At least annually, the organization must obtain ❑ obtain written confirmation from the state-licensing agency that it performs primary source verification. ❑ Sealed transcripts: If a practitioner submits transcripts

Primary Source Information:	Acceptable Sources:
<p>Is not required, but if practitioner lists it on the application, must be verified. If practitioner is board certified, verifying board certification fully meets standards for education and training.</p> <p>Verifies if applicable. Must be verified through one of the following sources: AMA, ABMS, ABA, AOA, AAMC.</p>	<p>to the organization that are in the institution's sealed envelope with an unbroken institution seal, NCQA accepts this as primary-source verification if the organization provides evidence that it inspected the contents of the envelope and confirmed that transcript shows that the practitioner completed (graduated from) the appropriate training program.</p> <p>Note: If the practitioner states that education and training were completed through the AMA's Fifth Pathway program, the organization must confirm it through primary-source verification from the AMA.</p> <p>Please refer to the applicable CMS, DMAS or its designee and NCQA standards required for non-doctors of medicine and osteopathy. Also, please refer to UHSMC's Credentialing Policies and Procedures.</p> <p>(MD, DO) board certification</p> <ul style="list-style-type: none"> ❑ ABMS or its member boards, or an official ABMS Display Agent, where a dated certificate of primary-source authenticity has been provided. ❑ AMA Physician Master File. ❑ AOA Official Osteopathic Physician Profile Report or AOA Physician Master File. ❑ Appropriate Specialty board State licensing agency, if the state agency performs primary-source verification of board status. At least annually, the organization must obtain written confirmation from the

Primary Source Information:	Acceptable Sources:
	<p>state-licensing agency that it performs primary-source verification.</p> <p>Please refer to the applicable CMS, DMAS or its designee, NCQA, and URAC standards for required for non-doctors of medicine and osteopathy. Also, please refer to UHSMC's Credentialing Policies and Procedures</p>
<ul style="list-style-type: none"> <input type="checkbox"/> Credential: Hospital Privileges <input type="checkbox"/> Type of Privileging: Full, Active (or equivalent status) and Current at a participating UHSMC hospital 	<ul style="list-style-type: none"> <input type="checkbox"/> Contact the hospital identified on the practitioner's application and use the hospital roster, fax, or other mode to confirm privileges
<ul style="list-style-type: none"> <input type="checkbox"/> State and Federal (Medicaid and Medicare) Sanctions, Restrictions on Licensure or Limitations on scope of practice, Exclusions and Limitations related to fraud and abuse and Opt In /Out status <input type="checkbox"/> Verification Time Limits: 180 cal days of Credentialing Meeting <p>The OIG and the Opt In/Opt Out listing must be queried for sanctions and limitations prior to presenting a practitioner to the Committee for review and a decision</p>	<p>Sources for Licensure Sanctions: Physicians:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Appropriate state agencies <input type="checkbox"/> Federation of State Medical Boards (FSMB) <input type="checkbox"/> Healthcare Integrity and Protection Databank (HIPDB) <input type="checkbox"/> National Practitioner Databank (NPDB) <p>Nonphysician behavioral healthcare professionals:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Appropriate state agency <input type="checkbox"/> HIPDB <input type="checkbox"/> State licensure or certification board <p>Sources for Medicare/Medicaid sanctions</p> <ul style="list-style-type: none"> <input type="checkbox"/> AMA Physician Master File entry <input type="checkbox"/> Federal Employees Health Benefits Plan (FEHB) Program department record, published by the Office of Personnel Management, Office of the Inspector General <input type="checkbox"/> FSMB <input type="checkbox"/> HIPDB

Primary Source Information:	Acceptable Sources:
	<ul style="list-style-type: none"> ❑ List of Excluded Individuals and Entities (maintained by OIG), available over the Internet ❑ Medicare and Medicaid Sanctions and Reinstatement Report, distributed to federally contracting organizations ❑ NPDB ❑ State Medicaid agency or intermediary and the Medicare intermediary ❑ Trailblazers.com – Opt In/Opt Out Website <p>Please refer to the applicable CMS, DMAS or its designee, NCQA, and URAC standards for required for non-doctors of medicine and osteopathy. Also, please refer to UHSMC’s Credentialing Policies and Procedures.</p>
<ul style="list-style-type: none"> ❑ Credential: Malpractice Insurance ❑ Verification Time Limit: 180 cal days (coverage limits are verified) <p>The plan must obtain confirmation of the past five years of history of malpractice settlements; some instances, the five-year period may include residency or fellowship years; the plan does not need to obtain confirmation from the carrier for practitioners who had a hospital insurance policy during a residency or fellowship.</p>	<ul style="list-style-type: none"> ❑ National Practitioner Data Bank ❑ Malpractice Carrier

Primary Source Information:	Acceptable Sources:
<ul style="list-style-type: none"> <input type="checkbox"/> Credential: Work History <input type="checkbox"/> Verification Time Limit: 180 cal days <p>NCQA does not require primary-source verification of work history; the organization must obtain a minimum of five years of relevant work history through the practitioner's application or CV; relevant experience includes work as a health professional; if the practitioner has practiced fewer than five years from the date of verification of work history, it starts at the time of initial licensure; experience practicing as a nonphysician health professional (e.g., registered nurse, nurse practitioner, clinical social worker) within the five years should be included. A gap exceeding six months must be reviewed and clarified either verbally or in writing; a CV or application must include the beginning and ending month and year for each position in the practitioner's employment experience; if a practitioner has had continuous employment for five years or more, then there is no gap and no need to provide the month and year, if the year meets the intent; verbal communication must be appropriately documented in the credentialing file; a gap in work history that exceeds one year must be clarified in writing.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Receipt of CV from practitioner <input type="checkbox"/> Completed Work History section on application

C. Practitioner Office Site Quality: Site Visit and Medical Record Keeping/Treatment Practices Assessments/Surveys:

UHSMC conducts an office site visit within 60 days for each member grievance/complaint received about the quality of all practitioner offices related to the following criteria:

- o Physical Accessibility (handicapped accessible, well lit exam rooms, posted office hrs)
- o Physical Appearance
- o Adequacy of Waiting- and Examining-Room Space

Member grievances will be monitored for all practitioner sites at least every six months.

Follow-up site visits will be conducted at least every six months until the threshold is met.

Offices are evaluated against applicable regulatory and accreditation standards, which have been adopted and incorporated into UHSMC policies and procedures

A random sampling of all practitioner offices are evaluated against applicable regulatory and accreditation standards, which have been adopted and incorporated into UHSMC policies and procedures

The office-site criteria include standards and thresholds for each of these categories.

- Physical Accessibility (handicapped accessible, well lit exam rooms, posted office hrs)

- Physical Appearance

- Adequacy of Waiting- and Examining-Room Space

- Availability of Appointments (timeliness of routine office visits, urgent visits)

- Adequacy of Treatment Record Keeping

UHSMC Staff discusses office documentation practices with practitioners or staff during site visits and medical record keeping/treatment reviews. This discussion includes methods on how to keep consistent information and ensure confidentiality of member records. Quality assurance forms, helpful aids, information on cultural competency, coordination of care PCPs and behavior health practitioners, advance directive information, safety brochures, etc. are given to practitioners or their staff during quality site visits.

UHSMC assesses medical/treatment records for orderliness and documentation practices. To ensure member confidentiality, the Quality Improvement Nurses may review "blinded" or "model" medical/treatment records for new offices. Actual records are reviewed during random site visits conducted to ensure UHSMC office site and MR standards are met. The review of medical/treatment record keeping practices does not have to include clinical elements, but may in some circumstances; therefore, clinical staff conducts these reviews.

The established performance threshold of 90% must be met for site visits and medical record keeping practices. If the assessment falls below the threshold, the practitioner will be required to develop and submit a corrective action plan. The Quality Improvement Nurse will assist and work collaboratively with the practitioner's office to institute interventions to correct any quality deficiencies.

In the event that the practitioner does not resolve the initial concern within the identified timeframe, the Quality Improvement Nurse will forward the quality issues, of immediate concern, to the Senior Medical Director for further guidance and action. The practitioner's office shall be re-evaluated at least every six months until the deficiency is resolved.

There will be documented follow-up visits for offices who have continued to fall below the established threshold. If the concern remains unresolved, the Senior Medical Director may recommend to the Credentialing Committee that the practitioner not be credentialed or recredentialed.

VIII. RECREDENTIALING: PRACTITIONERS

- A. UHSMC recredentials all practitioners within three (3) years of their last credentialing or recredentialing date. The intent of the process is to identify any changes that may affect a practitioner's ability to perform the services that s/he is under contract to provide.

All application requirements, detailed in Section: VII-A, are applicable to the recredentialing process. All verification time frames, for the applicable credential, detailed in Table: VII-B are applicable to the recredentialing process.

Each practitioner must complete and sign the UHSMC or CAQH Recredentialing Application that includes the professional questions and attestation that the information given is correct and gives UHSMC the right to verify the information. The following information is obtained and verified according to the standards and utilizing the sources listed under Initial Credentialing:

- State licenses (unrestricted, current and valid)
 - DEA/CDS certificate (if applicable; if DEA expires, the DEA Form must be completed)
 - Additional Education, if applicable
 - Board certification
 - Hospital affiliations/status of clinical privileges
 - Malpractice coverage
 - Malpractice claims
 - Sanction information
- B. The recredentialing process shall include performance-monitoring information. Sources of such information may include one or more of the following:
- Member grievances/complaints
 - Member and Practitioner/Provider satisfaction surveys
 - Utilization Management
 - Risk Management
 - Quality improvement activities, performance quality measures, quality deficiencies, and/or trending patterns
 - Site Assessments
 - Medical Record Keeping Practice/Treatment Assessments

Please Note: A practitioner will receive one of the following designations from the Committee:

A	Approved without reservation
B	Approved with reservation (follow up within one year)
C	Not approved because of insufficient data
D	Not approved (final decision)

After a practitioner has been credentialed, UHSMC shall not prohibit or otherwise restrict any participating (or nonparticipating) practitioner, acting within the lawful scope of practice, from advising, or advocating on behalf of, a member who is a patient about:

1. The patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options
2. The risks, benefits, and consequences of treatment or non-treatment
3. The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

Participating practitioners must provide information regarding treatment options in a culturally competent manner, including the option of no treatment. They must ensure that enrollees with disabilities have effective communications with participants throughout the health system in making decisions regarding treatment options.

IX. PRACTITIONER RIGHTS:

A. To Correct Erroneous Information

UHSMC's policy does not preclude the right of practitioners to review and correct erroneous information obtained to evaluate their credentialing application from outside primary sources to include, but not limited to, malpractice insurance carriers, state licensing boards, etc., with the exception of references, recommendations or other peer-review protected information, if applicable. UHSMC is not required to reveal the source of information if the information is not obtained to meet organizational credentialing verification requirements or if the law prohibits disclosure.

UHSMC policies and procedures state the practitioner's right to correct erroneous information submitted by a source. The policy clearly states:

- ❑ The time frame for changes
- ❑ The format for submitting corrections
- ❑ The person to whom corrections must be submitted
- ❑ The documentation of receipt of the corrections
- ❑ How practitioners are notified of their right to correct erroneous information (avenues identified under Right to review information, above, are appropriate).

Upon acceptance by the Committee, each new practitioner and provider, as applicable, is provided training materials in compliance with Privacy Rule workforce training mandates of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The practitioner data (education, training, board certification status and specialty) provided in the provider directory (education, training, board certification status and specialty) and other materials for members is consistent with credentialing data. UHSMC conducts data reconciliations at least annually to ensure data integrity.

B. To Review Information

UHSMC ensures that practitioners can access their own information obtained by UHSMC during the credentialing process and used to support their credentialing application. Practitioners shall be notified, in writing, of this right via one or more of the following methods:

- ❑ Applications
- ❑ Contracts
- ❑ Practitioner and/or Provider manuals
- ❑ Provider Newsletters
- ❑ Mail
- ❑ Email

- Fax
- Website
- Other Suitable Method

C. To Be Informed Of Application Status

UHSMC's written policy is to notify a practitioner of his/her application status, upon request. The process allows for phone calls, emails, letters, or faxes from practitioners. If either the credentialing staff or another department receives a request it shall be responded to within 72 hours of receipt. If another department receives a request, it will be routed to the Credentialing Department within one business day for follow-up and resolution, by the Credentialing staff, within 72 hours of initial receipt.

The Credentialing Department staff can advise the practitioner, once key information is verified, of the following information via phone or in writing, if requested by the practitioner:

- The date the application was received
- The status of the application – pending for additional information, etc.
- The date the application is tentatively scheduled to be presented to the Committee
- Answer any questions the practitioner may ask

Prior to disclosing any practitioner information via phone, as credentialing information is confidential, the following must be verified by the Credentialing staff and confirmed by the practitioner:

- Practitioner's full name
- Practitioner's primary office location
- Practitioner date of birth
- The name, city and state of the school the practitioner graduated
- Year practitioner joined the UHSMC Network

D. To Be Notified Of His/Her Rights

Each prospective and existing practitioner has the right to be notified of the aforementioned rights and will be notified via one of the methods listed under "Right to Review Information" described above.

X. FILE RETENTION

Credentialing files shall be retained for at least seven years. Credentialing files are considered protected and confidential. Each practitioner has an electronic file in the credentialing database. File cabinets containing practitioner files shall be locked and/or secured after normal business hours. Offices containing practitioner files shall be secured, as practical or business appropriate, after normal business hours. Archived files are shipped offsite to a secure file retention company with a file destruction date set to seven years post Committee meeting. A list of these files is maintained for reference and is secure by employee password.

XI. REINSTATEMENT

If a practitioner is credentialed and leaves the network voluntarily or in such a way that UHSMC has not terminated the practitioner for quality issues or any other adverse or egregious event, she/he may re-enter the network within thirty (30) calendar days, after submitting a written explanation to include activities during the absence, and completion of a recredentialing application without having to go through the primary source verification process, if all documents remain unrestricted, current and valid. UHSMC retains the right to recredential a practitioner in the event of a quality concern. The Senior Medical Director and/or the Committee retains the authority to approve or disapprove absences, on a case-by-case basis, regardless of the time frame absent from the network. UHSMC retains the right to initially credential a practitioner/provider in the event:

1. The practitioner/provider fails to respond to organizational request
2. The safety of a member may be compromised and/or
3. There is a business need

XII. ONGOING MONITORING

UHSMC monitors practitioner sanctions, grievances/complaints and quality issues between credentialing cycles and takes appropriate action(s) against practitioners when it identifies occurrences of poor quality. UHSMC acts on important quality and safety issues in a timely manner by reporting such occurrences at monthly credentialing meetings. If an occurrence requires urgent attention, the Senior Medical Director will address it immediately, engage the Committee if appropriate, and the appropriate action(s) shall be taken to ensure quality. On an ongoing monitoring basis, UHSMC collects and takes appropriate interventions and/or actions by:

- ❑ **Collecting and reviewing Medicare and Medicaid sanctions**
(UHSMC will review sanction information within 30 calendar days of its release from the OIG Report Website.
- ❑ **Collecting and reviewing sanctions or limitations on licensure:**
(UHSMC will review sanction information within 30 calendar days of its release. In areas where reporting entities do not publish sanction information on a set schedule, UHSMC will query for this information at least every six months).
- ❑ **Collecting and reviewing grievances/complaints:**
(UHSMC may evaluate both the specific grievance/complaint and the practitioner's history of issues, if applicable. Evaluation of the practitioner's history of grievances/complaints will occur at least every six months; if a trend is identified, a level three (3) rating is assigned, or if a practitioner has a combination thereof, the information will be presented at the next Committee Meeting for discussion).
- ❑ **Collecting and reviewing information from identified adverse events:**
(UHSMC monitors for adverse events at least every six months and determine if there is evidence of poor quality that could affect the health and safety of its members. Depending on the nature of the adverse event, UHSMC will implement actions based on its policies and procedures) (**An adverse event is an injury that occurs while a member is receiving health care services from a practitioner.**)
- ❑ Implementing appropriate interventions when it identifies instances of poor quality, when appropriate.

XIII. NONDISCRIMINATORY PRACTICES

UHSMC conducts each Committee meeting in a nondiscriminatory manner that does not include making decisions based solely on a prospective or existing practitioner's race, ethnic/national identity, gender, age, sexual orientation or types of procedures or patients in which the practitioner specializes.

A heterogeneous Committee will be maintained and the requirement for those responsible for credentialing decisions to sign a statement affirming that they do not discriminate when they make decisions is required.

Periodic audits of practitioner grievances/complaints will also be conducted to determine if there are grievances/complaints alleging discrimination. The following are procedures that will be followed by UHSMC staff and/or Committee Members to ensure a nondiscriminatory credentialing process:

- ❑ Prior to presenting a practitioner at the Credentialing Committee or other committee meeting, identifying information such as the practitioner or provider's name, social security number, address, telephone number, race, gender, etc. are **blinded** on each record by the Credentialing Department staff; identifying information on such reports as the Office of Inspector General (OIG), National Practitioner Data Bank (NPDB), the Department of Health Professions (DHP) reports, and other credentialing related reports are omitted.
- ❑ The types of procedures, types of members, etc. are never incorporated into the credentialing process.
- ❑ In the event that a practitioner or provider's identity is known, after taking all precautions above, the Chairman of the Credentialing Committee supports the abstention of Committee members, if s/he so declares

In credentialing practitioners, UHSMC shall not discriminate, in terms of participation, reimbursement, or indemnification, against any practitioner, prospective or existing, 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.

If a practitioner or group of practitioners is declined network participation, the reason for denial by the Committee shall be communicated in writing within 60 calendar days of the Committee's final decision.

This prohibition does not preclude UHSMC from refusing to grant participation to a practitioner if the network is sufficient.

XIV. PROVISIONAL CREDENTIALING

UHSMC, on an as needed basis and when in the interest of members, can make practitioners available prior to completion of the entire initial credentialing process. In this case, UHSMC will provisionally credential practitioners who are applying to the organization for the first time. A practitioner may only be provisionally credentialed once.

The following information must be verified prior to granting provisional credentialing status and prior to initial credentialing:

- ❑ Primary-source verification of the past five years of malpractice claims or settlements from the malpractice carrier, or the results of the national practitioner data bank (NPDB) query;
- ❑ Primary source verification of an unrestricted, current and valid license to practice; and
- ❑ A current and signed application with attestation.

Please note: Each factor (above) will be primary-source verified within 180 calendar days of the Committee Meeting Provisional credentialing files must contain the following, at a minimum:

- ❑ The Credentialing Committee's final decision
- ❑ Proof that the file has been in provisional status for no more than 60 calendar days.

Practitioners that have been provisionally credentialed will undergo the full credentialing process, to include a site visit, medical record keeping assessment, and the verification of all other information required for full credentialing on or within the 60 calendar day period.

XV. CREDENTIALING APPEAL REVIEW PROCESS

The Committee shall implement a mechanism to resolve disputes with participating practitioners (regarding actions by the organization that relate to either: a participating practitioner's status within the network or any action by the organization related to a practitioner's professional competency or conduct. (See **ATTACHMENT 3: APPEALS PROCESS**) In the case of any practitioner for which the Committee makes an adverse decision and recommends rejection of the application, it shall distinguish between a recommendation based on the following:

- **Business or Administrative**
 - Not related to the practitioner's competence or professional conduct

- **Competence and Professional Conduct – Quality Related**
 - As it affects or may affect the health and welfare of a member
 - Occurrences of this type, for physicians and non physicians, may be reported to the National Practitioner's Data Bank, the Department of Health Professions, the South Carolina Department of Labor, Licensing and Regulation, the American Medical Association, the Office of Inspector General, the Department of Health and Human Services and/or the Department of Medical Assistance Services

The Committee shall review all available information and notify each practitioner, in writing, via certified mail of its decision on whether to decline, suspend, reduce or terminate network privileges. In the event of an adverse event and prior to termination, a range of actions to improve performance may be provided to the practitioner (i.e., close panels to all new members, remove all members from a practitioner's panel, restrict a practitioner to perform specific duties, require oversight of surgical procedures by another participating surgeon, periodic reviews of medical records, require continuing medical education course(s), require attendance at in-service(s), etc) All practitioners adversely impacted shall receive instructions, in writing, on how to appeal a denied request for credentialing.

XVI. ORGANIZATIONAL PROVIDERS

- A. UHSMC conducts initial assessments and re-assessments of organizational providers with which it intends to contract to evaluate and confirm that the organizational provider has met regulatory and quality requirements as set forth by UHSMC policies and procedures, DMAS, NCQA, DHHS standards and any other applicable regulatory entities. Organizational providers will be re-assessed within three (3) years of the last assessment date or on a 36-month cycle.

Organizational providers include, but are not limited to:

Medical Providers:

Hospitals
Home Health Agencies
Skilled Nursing Facilities
Freestanding Surgical centers

Behavioral Health facilities providing mental health in the following settings:

Inpatient
Residential
Ambulatory

- B. Each organizational provider must meet minimum standards for participation with UHSMC. These guidelines are intended to comply with regulatory and accreditation standards established by the CMS, DMAS or its designee, NCQA, UHSMC and the laws of the Commonwealth of Virginia. The UHSMC standards for participation include:

- ❑ A valid, unrestricted (no limitations) license to do business and operate in any state where UHSMC has membership.
- ❑ Appropriate, as recognized by industry standard, professional liability insurance and comprehensive general liability insurance. If the organizational provider self-insures for medical malpractice insurance, then it must provide evidence of its established policy and adequacy of its funding arrangement and any reinsurance provisions.
- ❑ Unrestricted, current professional and business licenses, registrations, permits and certifications in good standing on all professional staff members, including certified nurses, and aides that may be called upon to deliver services, equipment and supplies.
- ❑ The provider is in good standing with State and Federal regulatory bodies; comply with all federal, state, local, city and county laws and regulations currently in effect or later enacted by these agencies as they relate to services rendered to members.
- ❑ The provider has been reviewed and approved by an accrediting body (see the accrediting bodies table immediately below); and if not, a site assessment will be conducted initially and within every 3 years thereafter. The survey results will then be communicated to the organizational provider seeking a contractual agreement with UHSMC and UHSMC's Credentialing and Contracting Departments.

- The Provider agrees to report changes in its licensure, certification, accreditation, ownership and location to UHSMC within five (5) calendar days of the change.

C. Accrediting bodies accepted by UHSMC are as follows:

Accreditation Association for Ambulatory Health Care	AAAHC
Accreditation Commission for Health Care, Inc.	ACHC
American Association for Accreditation of Ambulatory Surgery Facilities, Inc	AAASF
American Board for Certification in Orthotics and Prosthetics	ABCOP
American College of Radiology	ACR
Commission on Accreditation of Rehabilitation Facilities	CARF
Centers for Medicare and Medicaid Services	CMS
Healthcare Facilities Accreditation Program	HFAP
The Compliance Team, Inc.- Exemplary Provider (DME, Prosthetics, Orthotics, Supplies, Pharmacy, Homecare, etc)	DMEPOS
National Association of Speech and Hearing Center	NASHC
Rehabilitation Facilities Community	CHAP
The Joint Commission	The Joint Commission
Det Norske Veritas Healthcare, Inc. (DNV) - Hospitals <ul style="list-style-type: none"> • Accreditation Program Name: National Integrated Accreditation for Healthcare Organizations (NIAHO) • Approved by CMS: 09-26-08 (per Federal Register) 	DNV Healthcare/ NIAHO

D. Accreditation Standards include:

- Acute Care Hospital, Rehabilitation Hospitals, Psychiatric Hospitals, Partial Day Facilities: All Hospitals shall within three years of first commencing operations or on the effective date of the participating agreement, whichever is later, be accredited by JCAHO or DNV/NIAHO. All Hospitals shall have Medicare approval unless written documentation of non-applicability is accepted by UHSMC.
- Skilled Nursing Facility (SNF): This service is not covered under the UHSMC Medicaid product line; however, this service is covered under the VPG product line.
- Ambulatory Surgery Centers: All Ambulatory Surgery Centers shall within three years of first commencing operations or on the effective date of the participating agreement, whichever is later, be accredited by JCAHO or the Accreditation Association for Ambulatory Health Care (AAAHC). All Ambulatory Surgery Centers shall have Medicare certification unless written documentation of non-applicability is accepted by UHSMC.
- Home Health (HH) Equipment Suppliers and Durable Medical Equipment (DME) Suppliers: All HH and DME Equipment Suppliers shall meet JCAHO accreditation standards for equipment management services and shall participate with Medicare or Medicaid. CMS and UHSMC site surveys are also conducted.

- ❑ Home Infusion therapy Supplies and Home Health Agency Suppliers: All Home Infusion therapy Supplies and Home Health Agency Suppliers shall be accredited by JCAHP for home infusion or home care or be accredited by the Community Health Accreditation Program (CHAP) in conjunction with Medicare or Medicaid certification.
- ❑ When applicable, the following may be substituted if the stated level of accreditation is absent/pending:
 - Site Review – conducted by the Quality Improvement Coordinators
 - Copy of License
 - Written plan for pursuing accreditation

E. Initial Assessment of Organizational Providers:

The organizational provider must submit a legible, complete and signed Master Agreement and Application. UHSMC contracting staff shall review the agreement for completeness.

UHSMC verifies licensure and liability insurance and confirms organizational providers are in good standing with state and federal regulatory bodies and approved by an accrediting body.

Credential to be Verified	Verification Source
License for: Home Health Agencies Hospitals & Ambulatory Care Centers Skill Nursing Facilities	State Medical or Professional Licensing Board
Malpractice	Certificate of Insurance (COI) obtained directly from the organizational provider.
Medicare/Medicaid Certification	Certification letter obtained directly from the organizational provider; OIG Exclusions listing
Accreditation	See the grid above.

F. Ongoing Assessment of Organizational Providers:

UHSMC utilizes a system that monitors expiration dates of state license, accreditation, certification and malpractice insurance and will directly contact the organizational provider in obtaining unrestricted, current copies of required documents.

G. Re-Assessment of Organizational Providers:

UHSMC re-verifies organizational providers within three years of their last assessment date. The intent of the process is to identify any changes that may affect an organizational provider's ability to perform the services they are under contract to provide.

Organizational providers must complete and sign an “Organizational Provider Re-Assessment” Application or comparable documents. The following information is obtained and verified according to the process for initial credentialing:

- ❑ Licensure
- ❑ Malpractice coverage Medicare/Medicaid Certification Accreditation

H. Tracking: Initial, ongoing and re-assessment outcomes of contracted organizational providers (medical and behavioral health) will be tracked and documented by the Credentialing staff in the following format:

Name of Organization	Type of Organization	Prior Validation Date/License Status	Current Validation Date/License Status	Prior Accredited Validation Date/Body Status	Current Accredited Validation Date/Body/Status	Prior Site Visit Date/Body Status	Current Site Visit Date/Body Status
Mega X	Ambulatory	4/1/2004; Active	4/5/2007; Active	4/10/2004 ; Name; Active	4/15/2007; Name; Active	NA	NA
Getting Better	Residential	3/2/2004; Active	3/17/2007 ; Active	NA	NA	2/2/2004; CMS Compliant	2/10/2007; CMS Compliant

XVII. DELEGATED CREDENTIALING:

A. UHSMC enters into delegated agreements with organizations to perform credentialing and recredentialing for prospective and existing UHSMC practitioners. Through the execution of a pre-site audit of policies, procedures and files (when available), a contractual agreement, annual assessments (after the initial assessment) of policies, procedures and files, and reporting requirements, UHSMC ensures the following:

- ❑ Each delegate follows CMS, DMAS, DHHS or its designee, NCQA, UHSMC and other required regulatory and accreditation requirements, as specified.
- ❑ At least semi-annual reporting and that the exchange of data is conducted in a timely, efficient, and effective manner.

UHSMC retains the right of accountability and oversight for credentialing and recredentialing activities of practitioners (to include behavioral health), in all instances and even if UHSMC delegates all or part of these activities. UHSMC retains the right to make the final decision to approve, deny, suspend, or terminate a practitioner, provider, vendor, or sites in situations where it has or has not delegated decision-making. Annually, UHSMC establishes and implements written procedures to ensure effectiveness.

Requirements and rights are reflected in the delegation agreements.

The following criteria must be met in order for UHSMC to enter into a delegated agreement:

- ❑ The delegated entity shall provide UHSMC data and information as requested per the delegated credentialing agreement.
- ❑ The delegated entity shall provide documentation to UHSMC describing how its data collection, information development, and verification process (es) are performed.
- ❑ UHSMC is provided sufficient, clear information on database functions that includes any limitations of information available from the delegated entity (for example, practitioners not included in the database); the time frame for delegated entity responses to requests for information; and a summary overview of quality control processes relating to data integrity, security, transmission accuracy, and technical specifications.
- ❑ UHSMC and delegated entity agree upon the format for the transmission of credentials information about an individual from the delegated entity.
- ❑ UHSMC can easily discern what information transmitted by the delegated entity is from a primary source and what is not.
- ❑ For information transmitted by the delegated entity that can go out of date (for example, licensure, board certification), the date the information was last updated from the primary source is provided by the delegated entity upon request.
- ❑ The delegated entity certifies that the information transmitted to UHSMC accurately presents the information obtained by the entity.

- ❑ UHSMC can discern whether the information transmitted by the delegated entity from a primary source is all of the primary source information in the agency's possession pertinent to a given item or, if not, where additional information can be obtained.
- ❑ UHSMC can engage the quality control processes of the delegated entity when necessary to resolve concerns about transmission errors, inconsistencies, or other data issues that may be identified from time to time.

UHSMC ensures through an initial pre-delegation audit and annual delegated audits thereafter that the following standards are met:

- ❑ The credentialing information collected and maintained in the verification process is accurate, up-to-date and supported by documentation.
- ❑ The delegated entity utilizes designated equivalent sources.
- ❑ The delegated entity queries the NPDB for information on adverse clinical privilege action taken by a health care entity.
- ❑ UHSMC obtains information regarding changes in a practitioner's credentialing status from the accredited hospital, delegated entity to which it delegates credentialing.

All delegated practitioners are subject to approval by the UHSMC Credentialing Committee and/or Senior Medical Director, at initial credentialing and recredentialing.

- B. In the event that UHSMC contracts with a delegate and the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation agreement will include the following provisions to ensure that the information will remain protected:
- ❑ A list of the allowed uses of PHI
 - ❑ A description of delegate safeguards to protect the information from inappropriate use or further disclosure
 - ❑ A stipulation that the delegate will ensure that subdelegates have similar safeguards
 - ❑ A stipulation that the delegate will provide individuals with access to their PHI
 - ❑ A stipulation that the delegate will inform the organization if inappropriate uses of the information occur
 - ❑ A stipulation that the delegate will ensure that PHI is returned, destroyed or protected if the delegation agreement ends.

Please note the following:

- ❑ If UHSMC conducts annual file audits of delegates one year, it is not required to conduct annual file audits the subsequent year if the delegate does not credential or recredential any practitioners before the next file audit is scheduled to occur. In this case, the delegate is required to submit proof that it did not credential or recredential any practitioners in between audit cycles. UHSMC shall maintain and meet all delegation oversight.

- ❑ A practitioner can participate under a delegated agreement and also be credentialed by UHSMC as a licensed independent practitioner. Please refer to the section on Dual Credentialing/Contracting. These providers are referred to as “dually contracted” providers.
- ❑ UHSMC conducts quarterly meetings with all contracted, delegated credentialing partners to ensure ongoing UHSMC, regulatory and accreditation compliance. Simplification of processes is also discussed in these statewide meetings.

XVIII. DUAL CREDENTIALING and CONTRACTING

A. Dually Credentialed:

UHSMC grants dual credentialing to participating practitioners who can satisfactorily demonstrate the appropriate level of education and training in the specialties s/he wishes to practice. Appropriate education and training must be provided to UHSMC, and if not, there must be satisfactory evidence, as determined by UHSMC, of experience and hours of practice in the desired specialties. These types of practitioners are considered “dually credentialed” practitioners. For example: An internal medicine doctor can act as a primary care physician and a specialist.

B. Dually Contracted:

UHSMC considers those practitioners contracted directly with UHSMC as a licensed, independent practitioner and also with a contracted delegated entity as “dually contracted” practitioners.



2009 Credentialing Program Description Signature Page:

Effective Date: February 1, 2010

APPROVED BY:

UHSMC Credentialing Committee Chairperson or designee

Date

UHSMC Continuous Quality Improvement Committee Chairperson or designee

Date

UHSMC Board of Director's Chairperson or designee

Date

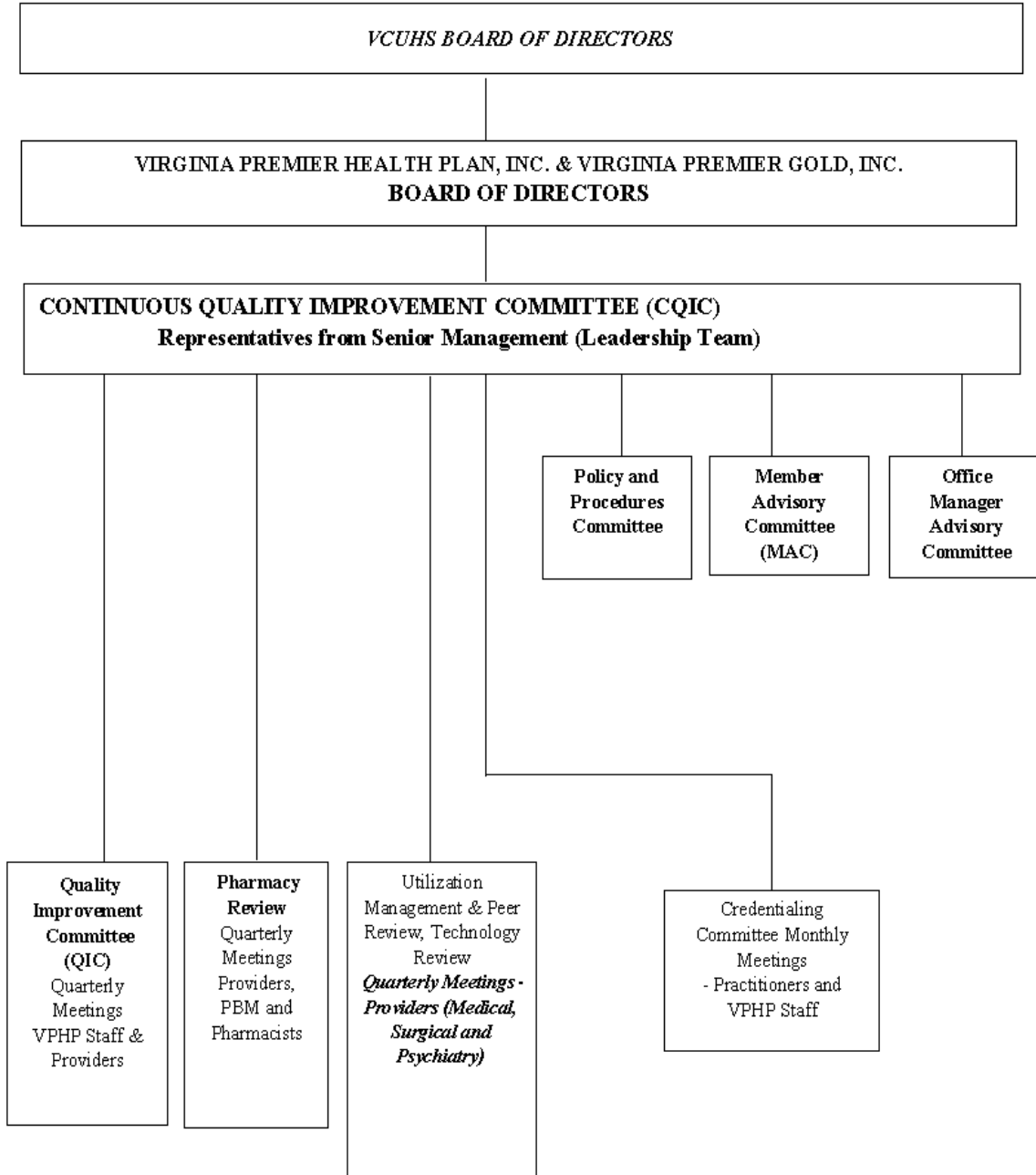
Original Date: **October 2000**

Reviewed Date(s): December 2001
October 2002
August 2003
August 2004
December 2005
February 2007
January 2008
February 2009
February 2010

Revised Date(s): December 2001
October 2002
August 2003
November 2004
December 2005
February 2007
January 2008
February 2009
February 2010

Attachment 1: Credentialing Structure and Governance

VIRGINIA PREMIER HEALTH PLAN, INC. ORGANIZATIONAL CHART



Attachment 2: DEA/CDS Certificate Form

The University Health Services Managed Care (UHSMC) Drug Enforcement Agency (DEA)/Controlled Drug Substance (CDS) Form serves as proof that the provider (noted below) does not hold a current and valid DEA/CDS Certificate and Number, issued by the Drug Enforcement Agency of the U.S.

This form allows providers to be credentialed or recredentialed, avoid suspension and possibly termination from the UHSMC Network. The form must be completed in its entirety, signed and dated by the provider. By doing so, the provider attests that all information entered on this form is accurate, truthful and will be adhered to.

SECTION 1: To be completed by the provider

By initialing below, the provider agrees to the following:

1. I, _____, do not hold a valid and current DEA/CDS Number and Certificate.
2. I, _____, shall not write medical or other prescriptions for medications for health plan members until I have duly notified UHSMC (as referenced in #3).
3. I, _____, shall notify and/or submit a copy of my valid and current DEA/CDS Certificate and Number to UHSMC within five (5) business days of receipt and/or notification.

SECTION 2: Covering Provider Information - To be completed by the provider

During the period in which I agree not to write medical or other prescriptions, the following physician, who is a participating provider, shall write prescriptions on my behalf:

Name of Covering Provider: _____

Address of Covering Provider: _____

Phone Number of Covering Provider: _____

SECTION 3: To be completed by the provider

Printed Name of the Provider

Signature of Provider

Date

SECTION 4: Office Use Only - To be completed by the Health Plan Representative

Printed Name of Health Plan Representative

Date

Vistar Key# or Medicaid Id#

Attachment 3:

University Health Systems Managed Care Appeal Process

A. Initial Review:

In reviewing applications, University Health Systems Managed Care (UHSMC) credentialing staff shall verify the information set forth in the application. The Credentialing Committee (The “Committee”) approves or denies all prospective and existing practitioners based on UHSMC policies and procedures and regulatory and accreditation standards.

UHSMC or the Committee does not make credentialing or recredentialing decisions based solely on a practitioner’s race, ethnic/national identify, gender, age, sexual orientation or type of procedure (e.g. abortions) or patient (e.g. Medicaid) in which the practitioner specializes. This does not preclude UHSMC or the Committee from including in its network practitioners who meet certain demographic or specialty needs; for example, to meet cultural needs of members.

The Committee shall make the final credentialing decision. The Committee shall implement a mechanism to resolve disputes with participating providers and practitioners regarding actions by the organization that relate to either: a participating practitioner’s status within the provider network; or any action by the organization related to a practitioner’s professional competency or conduct. In the case of any practitioner for which the Committee makes an adverse decision and recommends rejection of the application, the Committee shall distinguish between a recommendation based on the following:

- **Business or Administrative**
(not related to the practitioner's competence or professional conduct)
- **Competence and Professional Conduct**
(as it affects or may affect the health and welfare of a member)
Occurrences of this type may be reported to the National Practitioner’s Data Bank, the Department of Health Professions, the American Medical Association, and the Department of Medical Assistance Services

The Committee shall review all available information and notify each practitioner in writing via certified mail of its decision on whether to decline, suspend, reduce or terminate network privileges. In the event of an adverse event and prior to termination, a range of actions to improve performance may be provided to the practitioner (i.e., close panels to all new members, remove all members from a practitioner’s panel, restrict a practitioner to perform specific duties, require oversight of surgical procedures by another participating surgeon, periodic reviews of medical records, require continuing

medical education course(s), require attendance at in-service(s), etc). All practitioners adversely impacted shall receive instructions in writing on how to appeal a denied request for credentialing or recredentialing.

B. Denial/Appeal Categories:

Business or Administrative Related Denials (Regular Review and Appeal)

If the Committee decides not to accept an application of a practitioner for business or administrative related concerns (not related to the practitioner's competence or professional conduct), the Quality Improvement Manager (QIM) shall follow the "regular review and appeal" procedures established below should the practitioner exercise his/her right to appeal.

Competence and Professional Conduct Denials (Expanded Review and Appeal)

If the Committee decides not to accept an application of a practitioner based upon a concern for a practitioner's competence and professional conduct, the GAM shall follow the "expanded review and appeal" procedures established below should the practitioner exercise his/her right to appeal.

C. 1st Level - Business or Administrative Related Denials (Regular Review and Appeal):

Notification of the Denial by Mail

The Credentialing Staff, on behalf of the Committee shall notify the practitioner by mail of the denial. The Contracting Staff, on behalf of the Committee, shall notify a participating practitioner of suspension, reduction or termination of privileges in UHSMC's network. The Senior Medical Director and/or the designated person of the Committee shall sign all denial letter(s).

Each notice shall:

- (1) State the reason for the denial;
- (2) Notify the practitioner that he/she has the right to declare his/her intention to appeal by completing the Appeal Request Form and forwarding it to the QIM within thirty-
- (30) calendar days after receiving the notice.

The practitioner has the burden of establishing that he/she meets UHSMC's standards for participation. All appeals filed after the 30-calendar day timeframe are at risk for not being accepted. Appeals received outside of the 30 calendar day timeframe for filing shall be reviewed on a case-by-case basis.

Receipt of an Appeal

- When the QIM receives from a denied practitioner a written request for a 1st level business or administrative related appeal (Regular Review and Appeal) within 30 calendar days of the original denial, the QIM shall acknowledge receipt of the appeal in writing within 5 business days and shall

notify the Chair of the Credentialing Committee.

- The Chairman of the Committee shall appoint an impartial 1st level appeal panel to review the case unless the appeal request is:
 - 1) A breach in the practitioner's contract with UHSMC
 - 2) Failure to follow and/or adhere to UHSMC's policies and procedures
 - 3) A suspended, revoked or terminated license with the Board of Medicine, or other applicable regulatory agencies
- If any of the conditions listed above are present, the practitioner's appeal request will be considered on an individual basis at the discretion of the Chairman of the Credentialing Committee.
- The practitioner may submit additional written evidence to correct the record of erroneous information within thirty- (30) calendar days after notifying the QIM of his or her intention to appeal.
- The Chairman of the Credentialing Committee and/or designee shall review all pertinent information submitted by the practitioner and any other information from any source it deems relevant before making a final decision.
- A final decision shall be made within twenty – (20) calendar days from receipt of such information. The QIM shall be informed of the decision made.
- If no additional information has been received from the practitioner, Chairman of the Credentialing Committee or designee shall make a decision within fifty – (50) calendar days from the date of the practitioner's appeal's notice.
- If none of the conditions listed above are present, and the appeal request has been categorized as a regular review and appeal, the Chairman of the Credentialing Committee shall appoint an impartial 1st level appeal panel to review the case.
- The panel shall consist of at least 3 qualified individuals, such as plan representatives, committee members, committee practitioners, and/or network practitioners.
- From the 3 qualified individuals, at least one must be a participating practitioner who:
 - 1) Holds an active, unrestricted license to practice medicine or a health profession;
 - 2) Is board-certified (if applicable) by a specialty board approved by the American Board of Medical Specialties (doctors of medicine); or the Advisory Board of Osteopathic Specialists from the major areas of clinical services (doctors of osteopathic medicine);

- 3) Are in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate;
 - 4) Are neither the individual who made the original non-certification, nor the subordinate of such an individual.
 - 5) Is not otherwise involved in network management or in direct economic competition with the practitioner
 - 6) Who is a clinical peer of the participating practitioner that filed the dispute.
- The practitioner may submit additional written evidence, including statements by any relevant source, to correct the record or erroneous information, as it relates to the reasons for the initial denial, within thirty- (30) calendar days after notifying the QIM of his or her intention to appeal.
 - The impartial 1st level appeal's panel shall review all pertinent information submitted by the practitioner and any other information from any source it deems relevant before making its' recommendation.
 - Once additional information has been received from the practitioner, the 1st level appeal's panel shall make a decision within twenty – (20) calendar days from receipt of such information. The QIM shall be informed of the decision made.
 - If no additional information has been received from the practitioner, the 1st level appeal's panel shall make a decision within fifty – (50) calendar days from the date of the practitioner's appeal's notice.
 - The decision reached by the 1st level appeal's panel shall become a part of the record presented to the Chairman of the Committee.
 - The 1st level appeal's panel shall recommend that the initial decision be upheld (denied) or overturned (approved).
 - If the denial decision is upheld, the practitioner shall be informed in writing via certified mail that he/she has the right to file a 2nd level appeal.
 - If the practitioner elects to file a 2nd level appeal, the 1st level appeal's process shall be followed for business and administrative document review appeals, expanded document review appeals, and requests for hearings. However, upon conclusion of a 2nd level appeal, the decision of the Committee is final, unless overruled by UHSMC, as UHSMC reserves the right to overturn all panel decisions. No further appeal rights shall apply.

- Upon receipt of the panel's decision, the GAM shall forward the denied practitioner's record and the recommendation of the panel to the Chairperson of the Committee within ten- (10) calendar days after receiving the recommendation. The practitioner shall be informed of a decision in writing via certified mail, within ten- (10) calendar days after the Committee's decision.
- If the appeal is a 2nd level appeal, the practitioner will have exhausted all of his/her appeal rights, and the recommendation of the Committee shall be final, unless overruled by UHSMC, as UHSMC reserves the right to overturn all panel decisions. No further appeal rights shall apply.

D. 1st Level – Expanded Review and Appeal (Competence and Professional Conduct):

Notification of the Denial by Mail

The Credentialing Staff, on behalf of the Committee, shall notify a prospective practitioner by certified mail of the denial. The Senior Medical Director and/or the Chairperson of the Credentialing Committee shall sign the denial letter(s).

Each notice shall:

- (1) State the reasons for the proposed action in sufficient detail to allow the practitioner to prepare evidence in rebuttal;
- (2) Inform the practitioner that he/she has the right to request an appeal hearing or a document review on the proposed denial within thirty (30) calendar days after receiving notification;
- (3) Inform the practitioner that he or she is entitled to a summary of his or her rights during the hearing;
- (4) Inform the practitioner that he/she may declare their intention to appeal the denial by completing and forwarding the Appeal Request Form to the QIM within thirty- (30) calendar days after receiving the notice.

The practitioner has the burden of establishing that he/she meets UHSMC's standards for participation. All denied practitioners have 30 calendar days to request a review.

E. Receipt of a Request for a 1st Level Document Review Appeal**

- When the GAM receives from a denied practitioner a written request for a 1st level expanded document review and appeal (Competence and Professional Conduct) within 30 calendar days of the original denial, the GAM shall acknowledge receipt of the appeal in writing within 5 business days and shall notify the Chair of the Credentialing Committee.
- The Chairman of the Committee shall appoint an impartial 1st level appeal panel. The panel shall consist of at least 3 qualified individuals, such as Plan representatives, committee members, committee practitioners, and/or network practitioners.

- From the 3 qualified individuals, at least one must be a participating practitioner who:
 - 1) Holds an active, unrestricted license to practice medicine or a health profession;
 - 2) Is board-certified (if applicable) by a specialty board approved by the American Board of Medical Specialties (doctors of medicine); or the Advisory Board of Osteopathic Specialists from the major areas of clinical services (doctors of osteopathic medicine);
 - 3) Are in the same profession and in similar speciality as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate;
 - 4) Are neither the individual who made the original non-certification, nor the subordinate of such an individual.
 - 5) Is not otherwise involved in network management or in direct economic competition with the practitioner
 - 6) Who is a clinical peer of the participating practitioner that filed the dispute.

- The practitioner may submit additional written evidence, including statements by any relevant source, to correct the record or erroneous information, as it relates to the reasons for the initial denial, within thirty- (30) calendar days after notifying the QIM of his or her intention to appeal.

- The 1st level appeal's panel shall review all pertinent information submitted by the practitioner and any other information from any source it deems relevant before making its' recommendation.

- Once additional information has been received from the practitioner, the 1st level appeal's panel shall make a decision within twenty – (20) calendar days from receipt of such information. The QIM shall be informed of the decision made.

- If no additional information has been received from the practitioner, the 1st level appeal's panel shall make a decision within fifty – (50) calendar days from the date of the practitioner's appeal's notice.

- The decision reached by the 1st level appeal's panel shall become a part of the record presented to the Chairman of the Committee.

- The 1st level appeal's panel shall recommend that the initial decision be upheld (denied) or overturned (approved).

- If the denial decision is upheld, the practitioner shall be informed in writing that he/she has the right to file a 2nd level appeal.
- If the practitioner elects to file a 2nd level appeal, the 1st level appeal's process shall be followed for business and administrative document review appeals, expanded document review appeals, and requests for hearings. However, upon conclusion of a 2nd level appeal, the decision of the Committee is final, unless overruled by UHSMC, as UHSMC reserves the right to overturn all panel decisions. No further appeal rights shall apply.
- Upon receipt of the panel's decision, the QIM shall forward the denied practitioner's record and the recommendation of the panel to the Chairperson of the Committee within ten- (10) calendar days after receiving the recommendation. The practitioner shall be informed of a decision in writing via certified mail, within ten- (10) calendar days after the Committee's decision.
- If the appeal is a 2nd level appeal, the practitioner will have exhausted all of his/her appeal rights, and the recommendation of the Committee shall be final, unless overruled by UHSMC, as UHSMC reserves the right to overturn all panel decisions. No further appeal rights shall apply.

F. Receipt of a Request for A 1st Level Appeal Hearing

- When the GAM receives from a denied practitioner a written request for a 1st level expanded review (Competence and Professional Conduct) appeal hearing within 30 calendar days of the original denial; the QIM shall acknowledge receipt of the appeal hearing request in writing within 5 business days and shall notify the Chair of the Credentialing Committee.
- The practitioner shall be informed of acceptance of a hearing according to the expanded review procedures established in this section, which conform to the requirements of the Health Care Quality Improvement Committee Act of 1986. Moreover, the practitioner has no procedural rights, other than those set forth herein or required by law, at any such hearing.
- If the practitioner requests a Section 412 expanded review and appeal hearing within 30 calendar days of the initial denial, the QIM shall notify the practitioner of the place, time, and date of the hearing. The hearing shall be scheduled no less than thirty- (30) calendar days from the date of the request from the practitioner, unless the practitioner voluntarily agrees to an earlier hearing, and a list of witnesses (if any) expected to testify at the hearing on behalf of the Committee.
- The Chairman of the Committee shall appoint an impartial 1st level appeal panel. The panel shall consist of at least 3 qualified individuals, such as Plan representatives, committee members, committee practitioners, and/or network practitioners.

- From the 3 qualified individuals, at least one must be a participating practitioner who:
 - 1) Holds an active, unrestricted license to practice medicine or a health profession;
 - 2) Is board-certified (if applicable) by a specialty board approved by the American Board of Medical Specialties (doctors of medicine); or the Advisory Board of Osteopathic Specialists from the major areas of clinical services (doctors of osteopathic medicine);
 - 3) Are in the same profession and in similar speciality as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate;
 - 4) Are neither the individual who made the original non-certification, nor the subordinate of such an individual.
 - 5) Is not otherwise involved in network management or in direct economic competition with the practitioner
 - 6) Who is a clinical peer of the participating practitioner that filed the dispute.

- The practitioner may submit additional written evidence, including statements by any relevant source, to correct the record or erroneous information, as it relates to the reasons for the initial denial, within thirty- (30) calendar days after notifying the QIM of his or her intention to appeal.

- The right to a hearing may be forfeited if the practitioner fails, without good cause, to appear. In the hearing, the practitioner involved has the right: (i) to representation by an attorney or other person of the practitioner's choice, (ii) to a record of the proceeding, copies of which may be obtained by the practitioner upon payment of reasonable charges associated with preparation of the record, (iii) to call, examine, and cross-examine witnesses, (iv) to present evidence determined to be relevant by the hearing officer or committee designated above, regardless of its admissibility in a court of law, and (v) to submit a written statement at the close of the hearing.

- If the practitioner decides to be represented by an attorney or to have an attorney present to advise him or her at the hearing, the practitioner shall notify the GAM at least five- (5) calendar days before the hearing. The QIM shall inform the Chairman of the Credentialing Committee of the practitioner's request to have an attorney present.

- Once additional information has been received from the practitioner, the 1st level appeal's panel shall make a decision within twenty – (20) calendar days from receipt of such information. The QIM shall be informed of the decision made.

- If no additional information has been received from the practitioner, the 1st level appeal's panel shall make a decision within fifty – (50) calendar days from the date of the practitioner's appeal's notice.
- The decision reached by the 1st level appeal's panel shall become a part of the record presented to the Chairman of the Committee.
- The 1st level appeal's panel shall recommend that the initial decision be upheld (denied) or overturned (approved).
- If the denial decision is upheld, the practitioner shall be informed in writing that he/she has the right to file a 2nd level appeal.
- If the practitioner elects to file a 2nd level appeal, the 1st level appeal's process shall be followed for business and administrative document review appeals, expanded document review appeals, and requests for hearings. However, upon conclusion of a 2nd level appeal, the decision of the Committee is final, unless overruled by UHSMC, as UHSMC reserves the right to overturn all panel decisions. No further appeal rights shall apply.
- Upon receipt of the panel's decision, the QIN shall forward the denied practitioner's record and the recommendation of the panel to the Chairperson of the Committee within ten- (10) calendar days after receiving the recommendation. The practitioner shall be informed of a decision in writing via certified mail, within ten- (10) calendar days after the Committee's decision.
- If the appeal is a 2nd level appeal, the practitioner will have exhausted all of his/her appeal rights, and the recommendation of the Committee shall be final, unless overruled by UHSMC, as UHSMC reserves the right to overturn all panel decisions. No further appeal rights shall apply.

**University Health Systems Managed Care
Appeal Request Form**

Practitioner's Name: _____

Medicaid ID: _____

Practitioner's Specialty: _____

Practitioner's Address: _____

Practitioner's Phone #: _____ Fax: _____

Practitioner's E-Mail: _____

UHSMC's Denial

Reason: _____

Practitioner's Rebuttal: _____

(If additional space is required, please attach using a separate sheet of paper.)

Additional Comments _____

I am requesting the type of appeal review checked below. I understand that I am not required to attend document investigations.

Regular Review and Appeal Document Investigation

Expanded Review and Appeal Document Investigation

Expanded Review and Appeal Hearing (only applicable to expanded review and appeal cases)

*All appeals will be governed under the Regular Review or the Expanded Review and Appeal's process unless otherwise noted.

Practitioner's Signature:

Date:

Please note: The Appeal Request Form must be completed, signed and dated by the practitioner who is filing the appeal in order to be considered valid. If there is supporting documentation, please attach it to the Appeal Request Form.