

## Our Provider Credentialing Program

### *Who we credential*

Anthem issues credentials to these contracted health care practitioners:

- Medical doctors
- Doctors of osteopathic medicine
- Doctors of podiatry
- Chiropractors
- Doctors of optometry
- Doctors of dentistry and oral maxillofacial surgeons who provide services covered under the medical benefits plan

In addition, the law requires that we provide HIV infected members with access to providers with demonstrated expertise in treating HIV or AIDS.

We also credential these behavioral health practitioners:

- Psychiatrists and physicians who are certified or trained in addiction psychiatry, child and adolescent psychiatry, and geriatric psychiatry
- Doctoral and clinical psychologists who are state licensed
- Master's level clinical social workers who are state licensed
- Master's level clinical nurse specialists or psychiatric nurse practitioners who are nationally and state certified and state licensed
- Other behavioral health care specialists who are licensed, certified, or registered by the state to practice independently

We also issue credentials to other individual health care providers listed in our network directory.

We also credential these contracted Health Delivery Organizations (HDOs) for participation in our network:

- Acute care hospitals
- Home health agencies
- Skilled nursing facilities
- Nursing homes
- Free-standing surgical centers
- Lithotripsy centers treating kidney stones
- Free-standing cardiac catheterization labs
- Behavioral health facilities providing mental health and/or substance abuse treatment in an inpatient, residential or ambulatory setting.

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### *Our Credentials Committee*

Anthem's credentials committee (CC) is a peer review body that decides to accept, keep, deny or end a practitioner's participation in Anthem's programs or networks. The committee reports to the Plan's governing board and meets at least once every 45 days. A majority of voting committee members constitutes a quorum. The medical director, or a designated medical director accountable for credentialing program oversight, or appointed in conjunction with the vice president of Medical Policy, Technology Assessment and Credentialing will serve as a voting member and provide support to the credentialing/recredentialing process as needed.

The committee will include at least two participating practitioners. One of them will practice in the specialty type that most frequently provides services to our members. This practitioner will also fall within the scope of the credentialing program, and have no other role in managing Anthem's network. The committee chair may appoint additional participating practitioners with specialties that will help the committee operate efficiently.

The committee will meet with appropriate specialists when it reviews a practitioner's credentials. To make sure this process is fair and unbiased, a committee member will disclose certain information and refrain from voting on a practitioner if:

- the committee member believes there is a conflict of interest, such as direct economic competition with the provider
- has been professionally involved with the practitioner
- feels his or her judgment might otherwise be compromised

If the committee decides to deny an applicant, or end a practitioner's or Health Delivery Organization's participation in an Anthem program or network, this decision must be made by a majority vote of the voting committee members. And a majority of these voting members must be participating providers.

Our verification of credentials is ongoing and up-to-date, and the recredentialing process is implemented every three years. The CC, which meets on a predetermined basis, may have additional meetings called by the Chair of the CC on an as-needed basis.

It's important to note that all information used during the credentialing process is extremely confidential. All committee meeting minutes and professional practitioner files can't be copied or distributed and are stored in locked cabinets. Only our credentialing staff, medical directors, and committee members can access these files. And when they do, it can only be for confidential peer review and credentialing purposes consistent with applicable state and federal laws including, but not limited to Section 1157 of the California Evidence Code and Section 1370 of the California Health and Safety Code.

We notify practitioners that they have the right to review information that supports their credentialing applications. If we can't verify the credentialing information or if we find a discrepancy, we'll contact practitioners within 30 calendar days and let them know they have a right to correct wrong information. We'll also provide details about the issue in question, how to submit more information and where to send it.

Depending on the topic, we'll communicate verbally or in writing, and we'll send a written confirmation of any verbal communication. We'll clearly document all communication in the

practitioner's credentials file, including copies of the correspondence or a detailed record of phone calls. The provider has 14 calendar days to provide additional information.

If we need to correct or explain incomplete, inaccurate, or conflicting credentialing information, we may ask the provider for additional information. The committee will review the information and rationale presented by the provider to see if any information is missing or if the provider meets other credentialing criteria.

### ***Our Policy of Nondiscrimination***

We don't discriminate against any provider for participation in our programs or networks on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis that we don't specifically mention here. And we won't discriminate against any providers on the basis of the risks of the population they serve or against those who specialize in treating costly conditions. This type of information is not required in the credentialing and re-credentialing process. We only need to know the provider's gender and language capabilities so that we can meet the needs and preferences of our members.

Our credentialing program standards determine which practitioners and providers need additional review. These program standards relate to professional conduct and competence, (see Credentialing Policy #8) and our credentials committee decisions are based on these standards.

### ***Our Initial Credentialing Process***

To participate in our programs or networks, each practitioner or provider needs to complete a standard application form. The application form may be required by the state or it may be a standard form that we'll either create or accept. We use the Council for Affordable Quality Healthcare (CAQH) form for practitioners. CAQH is building the first national provider credentialing database system, which is designed to eliminate duplication when health plans, hospitals and providers collect and update provider information. To learn more about CAQH, please visit [www.CAQH.org](http://www.CAQH.org).

During the credentialing process, we'll verify an applicant's legal authority to practice, relevant training, experience and competency from original sources. All verifications need to be current and take place within the 180-day period before the credentialing committee makes its recommendation or verifications need to follow other usual accreditation standards.

During the credentialing process, we'll verify credentialing data in the following tables unless other regulatory or accrediting bodies require us to verify different data. These tables represent minimum requirements.

#### **A. Practitioners**

##### **What we verify**

- Your license to practice
- Your hospital admitting privileges at a hospital in each of our programs or networks where you participate or apply for participation
- Drug Enforcement Administration (DEA), Controlled Dangerous Substances (CDS) and state-controlled substance certificates

- These must be valid in the state(s) where you'll be seeing our members. If you see members in more than one state, you must have a DEA/CDS certificate for each state.
- Your malpractice insurance
- Your malpractice claims history
- Your board certification or highest level of medical training or education
- Your work history
- Any state or federal license sanctions or limitations
- Any Medicare, Medicaid or Federal Employee Health Benefit Plan (FEHBP) sanctions
- Your National Practitioner Data Bank report

#### B. Health Delivery Organizations

##### **What we verify**

- Your license to practice
- Your malpractice insurance
- Your Medicare certification
- Your Department of Health Survey results or recognized accrediting organization certification
- Any license sanctions or limitations
- Any Medicare, Medicaid or FEHBP sanctions

##### ***Our Recredentialing Process for Providers***

This process re-verifies and identifies changes in your license, sanctions, certification, health status and/or performance information. This includes, but is not limited to, malpractice experience, hospital privileges or other activities that may reflect on your professional conduct and competence. We review this information so we can assess whether our network practitioners and Health Delivery Organizations continue to meet our credentialing standards.

During the recredentialing process, we'll re-verify the credentialing data listed in the tables under initial credentialing, unless regulatory or accrediting organizations require us to re-verify additional data. Please note these tables list minimum requirements.

We must recredential all practitioners and HDOs in our network and in our credentialing program every three years unless contract or state regulations require us to re-verify additional data.

##### ***Health Delivery Organizations***

To determine whether our participating network HDOs meet appropriate standards of professional conduct and competence, they are subject to credentialing and recredentialing within the scope of our credentialing program. We recredential HDOs every 3 years unless regulatory or accrediting bodies require more frequent recredentialing. Each HDO that applies for continuing participation in our programs or networks needs to complete and submit a recredentialing application along with all the required supporting documentation.

New HDO applicants need to submit a standardized application to us for review. If applicants meet our screening criteria, we'll start the credentialing process. In addition to meeting our licensing and other eligibility criteria for participating HDOs, new HDO applicants are required

to maintain accreditation by an appropriate, recognized accrediting body. If there is no accreditation, we may evaluate the most recent site survey by Medicare or the appropriate state oversight agency for that HDO.

If they request it, we'll provide HDOs with the status of their credentialing application. We may request additional information from the HDO to correct incomplete, inaccurate, or conflicting credentialing information. Our credentialing committee will review this information and the rationale behind it to determine if something is missing or if other credentialing criteria are met.

### ***Ongoing Monitoring***

We've established an ongoing monitoring program to support credentialing standards between recredentialing cycles. We do this to help ensure compliance with credentialing standards and to monitor instances of possible substandard professional conduct and competence. Our credentialing department will review periodic listings/reports within 30 days of the time they are made available from these and other sources:

1. Office of the Inspector General
2. Federal Medicare/Medicaid reports
3. Office of Personnel Management
4. State licensing boards/agencies
5. Our Member/Customer Services Departments
6. Our Clinical Quality Management Dept. (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
7. Our internal departments
8. Any other verified information received from appropriate sources

When a participating practitioner or HDO has been identified by these sources, our response will include review by the chair of our credentialing committee, review by our medical director, referral to the credentialing committee, termination or other response. As required by law, our credentialing program will report practitioners to the appropriate authorities.

### ***Our Appeals Process***

If the information reviewed during the credentialing or recredentialing process shows that providers are not meeting professional conduct and competence standards, we may end their participation in our networks. It's our goal to treat participating and applying providers fairly, and provide them with a process to appeal rulings that end their participation for professional competence and conduct reasons. They may also appeal rulings that would result in a report to the National Practitioner Data Bank (NPDB). If providers, including HDOs, have been refused initial participation in our networks, they have the opportunity to correct any errors or omissions which may have led to the refusal.

We want to give practitioners the opportunity to appeal if they've been terminated from participating our networks or programs. This includes denials of requests for initial participation that we reported to the NPDB based on professional competence and conduct considerations. If a practitioner's license is suspended or lost, if there is a criminal conviction or if we determine that the practitioner may pose a risk of harm to our members, we may end the practitioner's

participation immediately. A practitioner whose license has been suspended or revoked does not have a right to informal review/reconsideration or formal appeal.

***Our Reporting Requirements***

When we take action on a professional review that affects a provider's participation in one or more of our networks, we may have an obligation to report this to the NPDB and/or the Healthcare Integrity and Protection Data Bank (HIPDB).

Once we receive a verified NPDB report, we'll send it to the state licensing board. Our credentialing staff will comply with all state and federal regulations that apply to reporting adverse actions that relate to professional conduct and competence, so we'll send these reports to the appropriate, legally designated agencies. If the procedures for reporting adverse actions conflict with the procedures in the current NPDB and HIPDB guidebook, we'll follow these guidebooks.

## OUR CREDENTIALING PROGRAM STANDARDS

### I. Eligibility Criteria

#### A. Health Care Practitioners

Those applying for the first time must meet the following criteria to be considered for participation:

1. Have a current, valid, unencumbered, unrestricted, and nonprobationary license in the states where he or she provides services to our members. Exception to this requirement may be made for those applicants whose licensure action was related to substance abuse and who have demonstrated a minimum of two years of successful participation in a treatment or monitoring program; should this exception be entertained, we may request specific documentation from the applicant's treating physician or program as we deem appropriate and to the extent permitted by law.
2. Have a current, valid, and unrestricted Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substances (CDS) registration for prescribing controlled substances, if this applies to the practitioner's specialty in treating our members. The DEA/CDS must be valid in the states(s) in which the practitioner will be seeing our members. Practitioners who see members in more than one state must have a DEA/CDS for each state.
3. Practitioners must not be currently debarred, excluded from participation, or placed on the Suspended and Ineligible Provider list for Medicare, Medicaid or the Federal Employees Health Benefits Program (FEHPB).
4. Applicants who are MDs and DOs must have current, in-force board certification in the clinical discipline for which they are applying as defined by: the American Board of Medical Specialties (ABMS), American Osteopathic Association, (AOA), Royal College of Physicians and Surgeons of Canada, (RCPSC), College of Family Physicians of Canada, (CFPC), Individuals will have five years after completion of their residency program or fellowship training program to meet this requirement. Applicants who are no longer eligible for board certification are not eligible for continued exception to this requirement.
  - a. As alternatives, MDs and DOs meeting any one of the following criteria will fulfill the education, training and certification requirement:
    - i. **Previous** board certification as defined by one of the following: ABMS, AOA, RCPSC or CFPC in the clinical specialty or subspecialty for which they are applying which has now expired AND a minimum of 10 consecutive years of clinical practice, OR
    - ii. Training that meets the requirements in place at the time it was completed in a specialty before the availability of board certifications in that clinical specialty or subspecialty, OR

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- iii. Specialized practice expertise shown by publication in nationally accepted peer review literature and/or recognized as a leader in their specialty AND a faculty appointment of Assistant Professor or higher at an academic medical center and teaching facility in our network AND professional activities spent at that institution at least 50 percent of the time.
5. Providers who meet one of these three alternative criteria (i, ii, iii) will fulfill all our education, training and certification criteria and won't be required to undergo additional review or individual presentation to our credentials committee. (see Credentialing Policies #4 and #8).
6. **We may review and approve these alternatives from time to time. We'll determine if applicant reports contain enough documentation to support alternative requirements. We reserve the right, in its reasonable discretion, to waive the board certification or the above alternative requirements when we determine that there are extenuating or special circumstances that warrant the waiver of such requirement.** This board certification requirement will not apply to MDs and DOs credentialed by us (or by an authorized delegated entity consistent with our credentialing policy) and in good standing in our managed care network as of the effective date of this policy unless they had been previously notified by us of the need to become board certified. All practitioners will continue to undergo oversight through the standard recredentialing mechanism. Additionally, the CC will assess unique situations where issues of limited access to care may dictate special consideration.
7. MD and DO applicants must have unrestricted hospital privileges at a hospital accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or the American Osteopathic Association-accredited hospital, or a network hospital approved by our credentialing committee. Some clinical disciplines may apply only to outpatient settings, so our credentials committee may decide hospital privileges aren't relevant to these specialties. Since an increasing number of physicians practice only in an outpatient or an inpatient setting, we'll evaluate applications from them without regard to hospital privileges. These physicians would usually have a referral arrangement with a network physician who provides inpatient care.
8. Applicants for initial participation in our programs or networks who do not meet the above criteria will be notified of this failure to meet these administrative criteria and their applications will not proceed through the credentialing process. However, networks not serving federal programs may review applicants debarred from Medicare, Medicaid and FEHBP on a case-by-case basis. In certain cases, **applicants who do not meet the above administrative criteria may be considered on an individual basis by our Credentials Committee.** Practitioners who do not meet the standard credentialing threshold will be individually reviewed by the Anthem Blue Cross Credentialing Committee. Those applying for continued participation in our programs or networks who do not meet the above administrative criteria will be



considered on an individual basis by the Credentials Committee pursuant to Credentialing Policy #8.

9. For DPMs (podiatrists), the applicant must be certified by either the American Board of Orthopedic and Primary Podiatric Medicine or the American Board of Podiatric Surgery. We reserve the right, in its reasonable discretion, to waive the board certification requirement when we determine that there are extenuating or special circumstances that warrant the waiver of such requirement.
10. Individuals will be granted five years after the completion of their residency to meet this requirement. However, individuals no longer eligible for board certification are not eligible for continued exception to this requirement.
11. This board certification requirement will not apply to podiatrists credentialed by us (or by an authorized delegated entity consistent with our credentialing policy) and in good standing in our managed care network as of the effective date of this policy, unless they had been previously notified by us of the need to become board certified. All practitioners will continue to undergo oversight through the standard recredentialing mechanism. Additionally, the CC will assess unique situations where issues of limited access to care may dictate special consideration.
12. For Oral and Maxillofacial Surgeons, the applicant must be certified by the American Board of Oral and Maxillofacial Surgery. We reserve the right, in its reasonable discretion, to waive the board certification requirement when we determine that there are extenuating or special circumstances that warrant the waiver of such requirement.
13. Individuals will be granted five years after completion of their residency to meet this requirement. However, individuals no longer eligible for board certification are not eligible for continued exception to this requirement.
14. This board certification requirement will not apply to Oral and Maxillofacial Surgeons credentialed by us (or by an authorized delegated entity consistent with our credentialing policy) and in good standing in our managed care network as of the effective date of this policy unless they had been previously notified by us of the need to become board certified. All practitioners will continue to undergo oversight through the standard recredentialing mechanism. Additionally, the CC will assess unique situations where issues of limited access to care may dictate special consideration certification.

## **II. Criteria for Selecting Practitioners**

### **A. New applicant (first-time credentialing)**

1. You must submit a complete application with the required attachments. Both must not contain any intentional misrepresentations.
2. Your signature dated within 180 days of the date you submit your application to us for a vote

3. Primary sources that verify your information within acceptable timeframes of the date you submitted your materials to us for a vote. These timeframes are those that appropriate accrediting agencies generally use.
4. No evidence of potential material omission(s) on your application
5. Site visit and medical record review results, if applicable, must meet our standards.
6. Current, valid, unrestricted license to practice in each state where you would provide care to our members
7. No current action on your license
8. No history of licensing board action in any state
9. No current federal sanction and no history of federal sanctions per Office of the Inspector General, (OIG), U. S. Department of Health & Human Services, U. S. Office of Personnel Management (OPM) report, and NPDB report.
10. Possess a current, valid, and unrestricted DEA and CDS registration for prescribing controlled substances, if this applies to treating our members in your specialty. The DEA/CDS must be valid in the state(s) where you'll be seeing our members.

Practitioners who see members in more than one state must have a DEA/CDS for each state. If first-time applicants have NO DEA/CDS certificate, they won't meet our criteria and the credentialing process will stop. But if you can provide evidence that you've applied for a DEA, the credentialing process can continue if you meet **all** of the following conditions:

- a. We can verify your application is pending
- b. You've made an arrangement for an alternative provider to prescribe controlled substances until your additional DEA certificate is obtained
- c. You agree to notify us when you receive the required DEA
- d. We can verify the appropriate DEA/CDS through standard sources
- e. You agree that failure to provide the appropriate DEA within a 90-day timeframe will result in ending your participation in our network
  - i. If you have a DEA certificate in a state other than the state in which you'll be seeing our members, we'll notify you that you need to obtain the additional DEA. If you have applied for an additional DEA, the credentialing process may continue if **all** the following are met:
- f. We can verify your application is pending
- g. You've made an arrangement for an alternative provider to prescribe controlled substances until your additional DEA certificate is obtained
- h. You agree to notify us when you receive the required DEA
- i. We can verify the appropriate DEA/CDS through standard sources

- j. You agree that failure to provide the appropriate DEA within a 90-day timeframe will result in ending your participation in our network.

AND

You must not be currently debarred or excluded from participation in Medicare, Medicaid or FEHBP.

1. You must not have any current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions.
2. You must have no history of or current use of illegal drugs or alcoholism.
3. You must not have an impairment or other condition which would have a negative impact on your ability to perform essential functions in your field.
4. There must not be a gap in your work history greater than six months in the past five years. The exception would be those gaps related to parental leave or immigration where 12-month gaps are acceptable. Other gaps in work history of six to 24 months will be reviewed by the chair of our credentialing committee and may be presented to the committee if the gap raises concerns of future substandard professional conduct and competence. If this is not a concern, our committee chair may approve work history gaps of up to two years.
5. No open indictments or convictions, or pleadings of guilty or no contest to a felony or any open indictments or convictions to any offense involving moral turpitude, or fraud or any other similar offense.
6. No other significant information, such as information related to boundary issues, or sexual impropriety or illegal drug use.

We'll evaluate a minimum of the past ten years of your malpractice case history including your current malpractice insurance face sheet for adequacy and compliance with the insurance limits as set forth in your Participating Provider Agreement with Plan (see Credentialing Policy #6).

7. As indicated on your application, you must meet credentialing standards for the education and training for the specialty or specialties that you would like to be listed under in our network directory. This includes board certification requirements or alternative criteria for MDs and DOs and board certification for DPMs and oral and maxillofacial surgeons.
8. You must have no involuntary terminations from an HMO or PPO
9. There must be no "yes" answers to attestation/disclosure questions on your application form. The **exceptions** are:
  - a. investment or business interests in ancillary services, equipment or supplies
  - b. voluntary resignation from a hospital or organization related to practice relocation or facility utilization
  - c. voluntary surrender of state license related to relocation or nonuse of your license

- d. an NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet threshold criteria
- e. malpractice coverage non-renewal or change in your malpractice carrier related to changes in the carrier's business practices. For example, no longer offering coverage in a state or no longer in business.
- f. previous failure of a certification exam if you are currently board certified or if you remain in the five-year post residency training window.
- g. actions taken by a hospital against your privileges related only to your failure to complete medical records in a timely fashion
- h. history of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

***Note: Our credentials committee will individually review any practitioner who does not meet one or more of the criteria for first-time applicants.***

*If you meet all criteria for first-time or continued participation and we can verify this, our credentialing chair may approve your application. This information may be in summary form and must include, at a minimum, your name and specialty.*

**B. Currently Participating Applicants (Recredentialing)**

1. You must submit a complete application with the required attachments. Both must not contain any intentional misrepresentations or falsifications.
2. Your signature dated within 180 days of the date you submit your application to us for a vote.
3. Primary sources that verify your information within acceptable timeframes of the date you submitted your materials to us for a vote. These timeframes are those that appropriate accrediting agencies generally use.
4. No evidence of potential material omission(s) on your recredentialing application.
5. A current, valid, unrestricted license to practice in each state in which you provide care to our members.
6. \*No current license probation
7. \*Your license is unencumbered.
8. You have no new history of licensing board reprimand since your previous credentialing review
9. \*You have no current federal sanction and no new (since prior credentialing review) history of federal sanctions according to OIG, OPM , or NPDB reports.
10. You have a current DEA and CDS certificate and/or state controlled substance certification without a new history of or current restrictions since your last credentialing review.

11. You have no current hospital membership or privilege restrictions and no new history of hospital membership or privilege restrictions since your last credentialing review. Or if you are a practitioner in a specialty that requires hospital privileges and practice only in an outpatient setting, you have a referral relationship with a provider of a similar specialty who provides inpatient care to members who need hospitalization. Both the referral provider and hospital must participate in our network.
12. No new history of or current use of illegal drugs or alcoholism since your previous credentialing review.
13. No impairment or other condition which would negatively impact your ability to perform essential functions in your field.
14. No open indictments or convictions, or pleadings of guilty or no contest to a felony or any open indictments or convictions to any offense involving moral turpitude, or fraud or any other similar offense since your previous credentialing review.
15. No other significant information, such as information related to boundary issues, or sexual impropriety or illegal drug use.
16. Your current malpractice insurance face sheet is adequate and compliant with the insurance limits as set forth in your Participating Provider Agreement with Plan (see Credentialing Policy #6).
17. No new, involuntary terminations from an HMO or PPO since your previous credentialing review.
18. No new “yes” answers on attestation/disclosure questions since your previous credentialing review. The **exceptions** are:
  - a. investment or business interests in ancillary services, equipment or supplies
  - b. voluntary resignation from a hospital or organization related to a practice relocation or facility utilization
  - c. voluntary surrender of your state license related to relocation or nonuse of your license
  - d. an NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet threshold criteria
  - e. malpractice coverage non-renewal or change in your malpractice carrier related to changes in the carrier’s business practices. For example, no longer offering coverage in a state or no longer in business.
  - f. previous failure of a certification exam if you are currently board certified or if you remain in the five-year post residency training window.
  - g. actions taken by a hospital against your privileges related only to your failure to complete medical records in a timely fashion
  - h. history of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

19. No Quality Improvement (QI) data, other performance data, including complaints, or other Plan-specific data above the set threshold.
  20. You have been recredentialed at least every three years to assess your continued compliance with our standards.
- \* Findings for currently participating practitioners will be most likely discovered through ongoing sanction monitoring. If we discover a finding for a provider, our credentials committee will individually review and consider it at the time the finding is identified.

*Note: Our credentials committee will individually review any practitioner who does not meet one or more of the criteria for recredentiaing.*

### **III. Additional Participation Criteria and Exceptions for Non-Physician Behavioral Health Providers Credentialing.**

You must have a minimum of two years experience post-licensure in the field in which you are applying. This experience must be beyond the training program. Or you must practice in a group setting where there is opportunity for oversight and consultation with a behavioral health practitioner with at least two years of post-licensure experience.

#### **A. License Type: Licensed Clinical Social Workers (LCSW) or other Master Level Social Work:**

1. You must have a masters or doctoral degree in social work with emphasis in clinical social work from a program accredited by the Council on Social Work Education (CSWE).
2. The program must have been accredited within three years of the time you graduated.
3. We require full accreditation. Candidacy programs will not be considered.
4. If your master's level degree doesn't meet our criteria and you obtained Ph. D. training as a clinical psychologist, but are not licensed, we'll be able to review you. To meet our criteria, your doctoral program must be accredited by the American Psychological Association (APA) or be regionally accredited by the Council for Higher Education Accreditation (CHEA). In addition, we'll accept a doctor of social work degree from an institution with at least regional accreditation from the CHEA.

#### **B. License Type: Licensed Professional Counselor (LPC) and Marriage and Family Therapist (MFT) or Other Master Level**

We'll accept a master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study listed above.

1. Master's or doctoral degrees in divinity **do not** meet criteria as a related field of study.
2. Your graduate school must be accredited by one of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post Secondary Education, APA, the Council for Accreditation of Counseling and Related Educational Programs (CACREP), or Commission on Accreditation for Marriage and Family Therapy

Education (COAMFTE) listings. The institution must have been accredited within three years of the time you graduated.

If a master's degree does not meet our criteria and you obtained Ph. D. training as a clinical psychologist, but are licensed, we will be able to review you. To meet our criteria, this doctoral program must either be accredited by the APA or be regionally accredited by the CHEA. We'll view as acceptable a doctoral degree in one of the fields of study noted above from an institution with at least regional accreditation from the CHEA.

**C. Clinical Nurse Specialist/Psychiatric and Mental Health Nurse Practitioner:**

1. You must have a master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing. Your graduate school must be accredited from an institution accredited by one of the Regional Institutional Accrediting Bodies within three years of your graduation.
2. You must have a registered nurse license and any additional licenses as an advanced practice nurse, certified nurse specialist, adult psychiatric nurse or other license or certification as required by the appropriate state board of registered nursing.
3. You must be certified by the American Nurses Association (ANA) in psychiatric nursing. This may be as a clinical nurse specialist in child or adult psychiatric nursing, psychiatric and mental health nurse practitioner or family psychiatric and mental health nurse practitioner.
4. You must have a valid, current, unrestricted Drug Enforcement Agency (DEA) certificate, where applicable, with appropriate supervision/consultation by a participating psychiatrist licensed by the state licensing board.] If you have a DEA certificate, we'll require the appropriate State Controlled Substance (SDS) certificate. The DEA/CDS must be valid in the state(s) where you'll be seeing our members. If you see members in more than one state, you must have a DEA/CDS for each state.

**D. Clinical Psychologists:**

1. You must have a valid state clinical psychologist license.
2. You must have a doctoral degree in clinical or counseling psychology or other applicable field of study from an institution accredited by the APA within three years of your graduation.
3. Education or training considered as eligible for an exception would be a provider whose doctoral degree is not from an APA-accredited institution but who is listed in the National Register of Health Service Providers in Psychology or who is a diplomate of the American Board of Professional Psychology.
4. If you are a master's level therapist in good standing in our network, and you upgrade your license to clinical psychologist as a result of further training, you're allowed to continue in the network and won't be subject to the education criteria listed above.

**E. Clinical Neuropsychologist:**

1. You must meet all the criteria for a clinical psychologist listed in C. 4 above and be board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical Neuropsychology (ABCN).
2. We may consider a provider who is credentialed by the National Register of Health Service Providers in psychology with an area of expertise in neuropsychology.
3. Our credentials committee will review clinical neuropsychologists who are not board certified nor listed in the National Register. These providers must have appropriate training and/or experience in neuropsychology by providing **one** of the following:
  - a. Transcript of pre-doctoral training OR
  - b. Documentation of formal one year post-doctoral training (participation in CEU training alone would not be considered adequate) OR
  - c. Letters from supervisors in clinical neuropsychology (including number of hours per week) OR
  - d. Minimum of five years' experience practicing neuropsychology at least 10 hours per week

**IV. Health Delivery Organization (HDO) Eligibility Criteria**

All Health Delivery Organizations must be accredited by an appropriate, recognized accrediting body. If the candidate meets our criteria, the credentialing process will commence. Accredited HDOs meeting all criteria will be viewed as Level I providers and may be approved by the chair of the Credentials Committee, or Plan medical director, or designee (see Credentialing Policy #3 and Credentialing Policy #8). This process applies to both credentialing and recredentialing.

If unique network needs cannot be met by an accredited HDO, we may review the most recent CMS or California Department of Health Care Services Survey. These HDOs will require individual review by the CC. This review may apply to either the credentialing or recredentialing process for such nonaccredited HDO.

In the absence of accreditation, we may evaluate the most recent site survey by Medicare or the appropriate state oversight agency. Our credentials committee will individually review non-accredited HDOs. These will be considered for access by our members only when our credentials committee review shows compliance with our standards and there are no deficiencies on the Medicare or state oversight review which would adversely affect quality of care or patient safety. We recredential HDOs at least every three years to assess their ongoing compliance with our standards.

**A. General Criteria for Health Delivery Organizations:**

1. A valid, current and unrestricted and nonprobationary license to operate in the state where it will provide services to our members. The license must be in good standing with no sanctions.
2. Valid and current Medicare certification.



3. The HDO must not be currently debarred or excluded for participation in Medicare, Medicaid or FEHBP
4. The HDO's liability insurance must be acceptable to us.
5. If the HDO is not appropriately accredited, our credentials committee must review a copy of its CMS or state site survey to determine if the HDO meets our quality and certification criteria standards.
6. Application and supporting documentation must not contain any material omissions or falsifications, including any additional information submitted or requested by us.
7. Complaints received from members or other providers may be reviewed for compliance with our standards.
8. Performance indicators obtained during the credentialing or recredentialing process, if applicable, must meet our standards.

### **B. Health Delivery Organization (HDO) Recredentialing**

Recredentialing of HDOs occurs every three years unless otherwise required by regulatory or accrediting bodies (see Credentialing Policies #4, #5 and #10).

In performing a recredentialing review, all HDOs will be evaluated for the status of their licensure and accreditation. HDOs that have appropriate state licensure without sanction, probation or other adverse action and that have maintained accreditation by an agency recognized by us (see Credentialing Policy #9) will be viewed as meeting all criteria and will be classified in the recredentialing process as Level I providers (see Credentialing Policy #8). These Level I HDOs may be approved by the chair of the CC, Plan medical director or designee as noted in Credentialing Policy #3.

HDOs that are not accredited by an accrediting body recognized in Credentialing Policy #9 will be evaluated at recredentialing with an assessment including the following elements:

- California Department of Health Care Services Survey Results – a copy of the most recent state survey will be obtained and reviewed. HDOs with any deficiencies (even if these have been subjected to a corrective action plan that has been accepted by the state) will require specific CC review for issues of patient safety.
- Center for Medicare and Medicaid Services (CMS) status – Those HDO types for which CMS assesses must be active CMS providers. In addition, the CMS website will be queried for applicable HDO types. In those instances where the California Department of Health Care Services Survey results reviewed in the above paragraph require individual committee review, the information from the CMS website may also be provided to the CC.

Upon request, HDOs will be provided with the status of their recredentialing application.

We may request and shall accept additional information from the HDO to correct incomplete, inaccurate or conflicting recredentialing information. The Credentialing Committee will review this information, the rationale presented and will determine if either a material omission has occurred or if other recredentialing criteria are met.

- The recredentialing application materials sent by us include, but are not limited to, the:

- Cover letter
- Recredentialing Application
- Attestation statement
- In completing the recredentialing application, each HDO must disclose the existence of, and provide explanations for, the following (since its last credentialing cycle):
  - Instances in which the HDO has been the subject of any investigation by any state licensing board or agency.
  - Instances in which the HDO's malpractice insurance has been terminated, denied, suspended or limited.
  - Convictions of HDO officers, whether as a result of a guilty plea, a plea of no contest or a verdict of guilty, of a felony, any offense involving fraud or any offense related to the practice of healing arts.
  - Instances in which the facility has been sanctioned, debarred, terminated or placed on the Suspended and Ineligible Provider list, as applicable, by Medicare, Medicaid, or the FEHBP or
  - Additional information requested by us to explain or provide details regarding responses obtained on the credentialing application.
- All HDO applications must include a signed and dated Attestation Statement that contains information, including, but not limited to:
  - History of loss of license and felony convictions
  - Current liability insurance coverage
  - The correctness and completeness of the application
- Each HDO must submit, along with the application, the following at a minimum:
  - Current state licenses and certificates as set forth in Credentialing Policy #4.
  - Current malpractice insurance face sheet
  - Medicare certification

We will consider accreditation from the following oversight organizations. Acceptable standards are noted after each type.

**C. Medical Facilities**

<b>Medical Care Facility</b>	<b>Acceptable Accrediting Agencies</b>
Acute Care Hospital	JCAHO, HFAP
Ambulatory Surgical Centers	JCAHO, HFAP, AAPSF, AAAHC, AAAASF, IMQ
Free Standing Cardiac Catheterization Facilities	JCAHO, HFAP (may be covered under parent institution)
Lithotripsy Centers (Kidney stones)	JCAHO
Home Health Care Agencies	JCAHO, HFAP, CHAP, ACHC

<b>Medical Care Facility</b>	<b>Acceptable Accrediting Agencies</b>
Skilled Nursing Facilities	JCAHO, HFAP, CARF
Nursing Homes	JCAHO

**D. Behavioral Health**

<b>Behavioral Health Care Facility</b>	<b>Acceptable Accrediting Agencies</b>
Acute Care Hospital—psychiatric disorders	JCAHO
Residential Care—psychiatric disorders	JCAHO, CARF
Partial hospitalization/day treatment—psychiatric disorders	JCAHO, CARF for programs associated with acute care facilities or residential treatment facilities
Intensive structured outpatient program—psychiatric disorders	JCAHO for programs affiliated with an acute care hospital or health care organization that provides psychiatric services to adults or adolescents  CARF if the program is a residential treatment center providing psychiatric services
Acute Inpatient Hospital—chemical dependency/detoxification and rehabilitation	JCAHO
Acute Inpatient Hospital—detoxification only facilities	JCAHO
Residential Care—chemical dependency	JCAHO or CARF
Partial hospitalization/day treatment—chemical dependency	JCAHO for programs affiliated with a hospital or health care organization that provides drug abuse and/or alcoholism treatment services to adults or adolescents;  CHAMPUS or CARF for programs affiliated with a residential treatment center that provides drug abuse and/or alcoholism treatment services to adults or adolescents
Intensive structured outpatient program— chemical dependency	JCAHO for programs affiliated with a hospital or health care organization that provides drug abuse and/or alcoholism treatment services to adults or adolescents;  CARF for programs affiliated with a residential treatment center that provides drug abuse and/or alcoholism treatment services to adults or adolescents.

## **V. Restriction, Suspension or Termination of the Practitioner's Participation with the Plan**

Certain provisions in this section (restriction, suspension or termination of the practitioner's participation with the Plan) are governed, in part, by (1) the federal Health Care Improvement Act of 1986, as amended, and (2) the applicable state laws governing peer review and agency reporting requirements that are set forth in California Business and Professions Code, as amended. (Collectively, (1) and (2) are referred to as the "Governing State and Federal Laws").

If we are unable to implement any applicable provision in this section, inclusive of any further updates, revisions and amendments, due to a conflict with the Governing State and Federal Laws, the Governing State and Federal Laws shall control and take precedence over the provisions of this section.

Actions adverse to a practitioner's participation in our programs or networks that are not based on concerns related to professional qualifications are not addressed in this section, except to the extent that such practices may have been determined to be unprofessional conduct or competence by the Credentials Committee. Examples of such actions that are not addressed in this section are those related to network over capacity, or unsatisfactory business or billing practices. These are viewed as administrative actions.

A practitioner's participation in our programs or managed care networks may be terminated for any lawful reason, including but not limited to failure to meet standard eligibility criteria due to a lapse in basic predetermined professional conduct and competence, credentialing criteria involving licensure (revocation, suspension or surrender), required medical staff membership, privileges, certification or accreditation.

Additionally, a practitioner's participation in our programs or managed care networks may be reassessed when we receive information relative to professional conduct and competence including, but not limited to a history of professional disciplinary actions, malpractice history, sanctions under Medicare, Medicaid or FEHBP, unprofessional conduct, moral turpitude, criminal convictions, reportable malpractice actions, loss or surcharge of malpractice insurance or other events that affect or could adversely affect the health or welfare of a patient reasonably calling into question the practitioner's ability, capacity or intent to deliver efficient, quality patient care.

Additionally, whenever a practitioner's conduct requires that immediate action be taken as continued participation in our programs or networks poses an imminent risk of harm to our members or if the practitioner's license is suspended, probated or revoked, a process for immediate termination may be invoked.

If, upon a recredentialing review or off-cycle review, the Credentials Committee renders a decision of suspension or termination for cause, the practitioner shall be so notified and advised of the right to appeal the determination. If the practitioner invokes the right to appeal, the practitioner shall be provided an appeal in accordance with procedure set forth in Credentialing Policy #14. If the practitioner does not invoke the right to an appeal or the appeals process upholds the Credentials Committee's decision to suspend or terminate, the practitioner, along with appropriate internal Plan departments, shall be notified of the effective date of termination.

## **A. Immediate Termination**

Routine issues raised about a practitioner's professional conduct or competence shall be reviewed by the chair of the Credentials Committee and referred to the Committee for review. However, when we receive information that a practitioner's continued participation in our programs or networks may pose some potential risk to the health or welfare of one or more of our members or may potentially result in imminent danger to the health or welfare of one or more of our members due to specific issues of professional conduct and competence, a process for immediate termination exists.

In instances where such imminent risk or danger may be present, the chair of the Credentials Committee or the Plan's medical director or designee, after consultation with legal counsel, may terminate the practitioner's participation in our programs or networks, effective immediately and provide notice to the practitioner. The investigation in support of such immediate termination may occur in an expedited time frame. The practitioner shall be sent a written statement by certified mail of this decision.

When the process for immediate termination is invoked, the action will be reported and reviewed in the next scheduled meeting of the Credentials Committee.

The practitioner may have the right to appeal, but participation may not be reinstated during the appeals process. If a decision to immediately terminate a practitioner is overturned on review or appeal, the practitioner shall be reinstated, and will not lose any of the protections to which a practitioner had been entitled before the immediate termination. These include the exemption from criteria such as certification or accreditation based on their prior participation.

## **B. Reporting**

We shall comply with the reporting requirements of state licensing agencies and the National Practitioner Data Bank and the Federal Healthcare Quality Improvement Act of 1986, as amended (see Credentialing Policy #12).

## **C. Notice and Request for First-Level Review**

### **1. Notice**

- Terminations of Participating Practitioners—Upon decision by the Credentials Committee to terminate a practitioner's participation, the credentialing staff will notify the practitioner by a certified letter of the decision. The notice will contain the reason for the decision, a statement that the practitioner has the opportunity for an informal review/reconsideration of the decision, a statement that the provider has the right to submit additional information to us for informal review/reconsideration and a summary description of the review process described below. The notice also will state that if the practitioner wants an informal review/reconsideration, the practitioner must submit, within the 30-calendar day period immediately following the date of receipt of the letter (unless otherwise required by state regulation), a written request to the credentialing department for a review of the decision, along with any additional information the practitioner wants to be considered. A request for an informal review/reconsideration shall not stay the effective date of the termination unless

- otherwise required by state law or regulation or by contract. For information regarding immediate terminations, see Credentialing Policy #11.
- Denial of Initial Applicants—Upon decision by the Credentials Committee to deny a practitioner’s participation, the credentialing staff will notify the practitioner by a certified letter of the decision. The letter will contain the reason for the decision, a statement that the practitioner has the opportunity to provide information to correct any errors in the factual information that led to the determination or provide other relevant information. The letter also will state that if the practitioner wants an informal review/reconsideration, the practitioner must submit, within the 30-calendar day period immediately following the date of receipt of the letter (unless otherwise required by state regulation), a written request to the credentialing department for a review of the decision, along with any additional information the practitioner wants to be considered.

## **2. Request for First-Level Review (Informal Review/Reconsideration)**

The practitioner may request a first level informal review/reconsideration of the Credentialing Committee’s decision if the decision of the Committee is adverse to the provider. This request must be in writing, sent by certified mail and received by the credentialing department within the 30-calendar day period immediately following the date of the practitioner’s receipt of the letter from us (unless otherwise required by state regulation), with its determination based on the Credentialing Committee results.

### **a. Meet-and-Confer**

If the contract between us and the practitioner gives the practitioner a right to meet-and-confer with us as part of the contractually defined dispute resolution process, the practitioner will be so advised at the time he/she is informed of the determination and further advised that he/she may within 30-calendar days of the date of mailing the notice request in writing a meet-and-confer with representatives of the Credentialing Committee. A meet-and-confer shall be an informal meeting between the practitioner and two or more representatives of the Committee designated by its chair. The chair may designate qualified individuals who are not members of the Credentialing Committee to act as its representative for the purposes of meet-and confer. The practitioner will be invited to present in an informal proceeding any information that he/she believes may have a bearing on the matter; and the representatives of the Committee will be free to ask questions of the practitioner. Following conclusion of the meet-and-confer, the representatives of the Committee will recommend a disposition of the matter to the Credentialing Committee at its next meeting, and the Committee will consider the recommendation and either sustain or set aside the termination or suspension of the practitioner. The practitioner shall be informed of the results of the meet-and-confer after the information is presented to the Credentialing Committee and a reconsideration determination is made (as described below).

**b. Alternative Dispute Resolution**

For practitioners who are terminated by a Credentialing Committee action, and whose contract does not give the right to a meet-and-confer, we may offer an alternative dispute resolution process prior to the informal hearing. This will be offered only when required by regulation or accreditation. This will include the right to consideration of all the information relevant to the determination by an authorized representative of the Plan who was not involved in the original determination. The practitioner will be so advised at the time he/she is informed of the determination and further advised that he/she may within 30-calendar days of the date of mailing the notice request in writing an alternative dispute resolution.

- The alternative dispute resolution shall be an informal meeting between the practitioner and one or more authorized representatives of the Plan not involved in the original determination and appointed by the chair of the Credentialing Committee. The chair may designate qualified individuals to represent us. The practitioner will be invited to present in an informal proceeding any information that he/she believes may have a bearing on the matter; and the authorized representative of the Plan will be free to ask questions of the practitioner.
- Following conclusion of the alternate dispute resolution, the representatives will recommend a disposition of the matter to the Credentialing Committee at its next meeting, and the Committee will consider the recommendation and either sustain or set aside the termination or suspension of the practitioner. The practitioner shall be informed of the results of the alternate dispute resolution process after the information is presented to the Credentialing Committee and a reconsideration determination is made (as described below). The practitioner making the appeal may waive this level of appeal and proceed directly to the informal hearing, and notification of this will be included with the letter advising the practitioner of its availability. Failure to request an alternate dispute resolution process will have no effect on any further determinations.

**c. Process**

Any additional information submitted subsequent to the initial decision will be reviewed by the credentialing staff for informal review/reconsideration. The credentialing staff will review the information used as the basis for the initial decision, along with any additional information submitted by the practitioner and if appropriate, forward the matter including any additional information submitted by the practitioner to the Credentialing Committee at its next meeting. The practitioner shall not be present during the informal review/reconsideration. For initial determinations, if the information submitted by the practitioner contains no new objective information, it may be presented in summary form.

**d. First-Level Review**

As a reconsideration, any additional information submitted subsequent to the initial decision of the Credentialing Committee will be presented to the committee for its

consideration. All of the conditions of Credentialing Policy #3 with regards to the Credentialing Committee apply. The Committee will review the information obtained during the credentialing process and the basis for its initial decision, along with any additional information submitted by the practitioner. For those cases where a meet-and-confer process has occurred, the results of this will be available as well. This review may take place at regularly scheduled Credentialing Committee meetings or at a special review meeting. The practitioner shall not be present during the review. We may have credentialing staff, network service representatives and legal representatives present for the first level review as nonvoting members.

**e. Review Results**

The Credentialing Committee shall report its decision on the first level review (informal review/reconsideration) to the credentialing department within five business days of its decision. The credentialing staff shall notify the practitioner by certified mail within 14 calendar days of the decision. For a practitioner requesting informal review/reconsideration of a denial for initial participation in the network, this is the final level of review, unless our action is to be reported to the National Practitioner Data Bank (NPDB).

Whenever an action is to be reported to the NPDB, the practitioner will be afforded the right to a formal hearing.

**3. Second-Level Appeal Process**

**a. Notice**

Upon notification that the informal review/reconsideration of a decision to terminate a practitioner's participation of a professional review action was upheld by the Credentialing Committee, the credentialing staff will notify the practitioner by certified letter of the decision. The notice will:

- Contain the reason for the decision
- Where a practitioner is eligible for a formal appeal, a statement that
  - -the practitioner has the opportunity to submit additional information to us for formal -appeal of the decision and
  - -a summary description of the formal appeal process as described below
- State that if the practitioner wants a formal appeal, the practitioner must submit, within the 30-calendar day period immediately following the date of receipt of the notice (unless otherwise required by state regulation)
  - -a written request to the credentialing department for an appeal of the decision and any additional information the practitioner wants to be considered



- A request for a formal appeal shall not stay the effective date of the termination, unless otherwise required by state law or regulation or by contract.

#### **4. Formal Hearing Upon Request**

As a second level of review, the practitioner whose termination from the network or whose denial for initial participation will be reported to the NPDB may request a formal hearing. This request must be in writing and received by certified mail within the 30-calendar day period immediately following the date of the practitioner's receipt of the notice from us. If a practitioner timely requests a hearing, the following procedures will be followed:

- The credentialing staff will notify the Plan's medical director, and the Plan's legal counsel, of the practitioner's request for a hearing.
- Hearing Panel—The Plan's medical director or designee will select the members of the hearing panel. The hearing panel will be comprised of at least three practitioners not involved in the original decision. Only hearing panel members not involved in the original decision may vote. No person who is in direct economic competition with the practitioner may serve on the hearing panel. At least one of the hearing panel members will be a clinical peer. The hearing panel will be chaired by the Plan's medical director or designee who is entitled to vote and who is counted as a member of the hearing panel.
- Hearing Notice—Within 30 business days of receipt by us of a practitioner's request for a formal appeal, the credentialing staff will send a certified letter notifying the practitioner of the date, time and place of the formal hearing. It will advise the practitioner that he/she may appear in person or by telephone. This letter will also summarize the hearing procedures and notify the practitioner that he or she may appear with a legal representative or other designee before the hearing panel, and that such practitioner has the right to
  - have a record made of the proceedings, copies of which may be obtained by the practitioner upon payment of any reasonable charges associated with the preparation thereof
  - call, examine and cross-examine witnesses
  - present evidence determined to be relevant by the hearing panel regardless of its admissibility in a court of law
  - submit a written statement at the close of the hearing
  - receive upon completion of the hearing, the written decision of the panel, including a statement of the basis for the decision
    - Such notice will also state that the practitioner will forfeit his or her right to a hearing if the practitioner fails to attend the hearing (either in person or by telephone) without good cause

- In advance of the hearing, the credentialing staff will give each hearing panel member a copy of the denial or termination letter originally sent to the applicable practitioner. The panel members may also be provided with any other material deemed relevant by us at or in advance of the hearing.
- **Hearing Date**—The hearing date will be not less than 30 nor more than 60 calendar days after the date of the notice given to the practitioner of the date, time and place of the formal hearing or as otherwise agreed to by us and the affected practitioner.

**a. Hearing Procedures**

The chairperson of the hearing panel, who is the medical director or his/her designee, will open the hearing by stating the purpose and protocol of the hearing.

- During the hearing, the practitioner will have the ability to exercise any or all of the rights as set forth in the Hearing Notice subsection above
- Our representative will present the reasons for the decision to reject or terminate the practitioner
- The practitioner will present reasons why his/her participation should not be rejected or terminated
- Before the close of the hearing, each side may briefly summarize its position for the hearing panel if it chooses
- The maximum duration of the hearing will be two hours unless the chairperson of the hearing panel, in his or her discretion, determines that the hearing cannot reasonably be concluded in that time period
- The hearing panel will meet privately after the hearing to reach a decision. Each voting member of the hearing panel will have one equal vote. The hearing panel will have the authority to uphold, reject or modify the original decision based on a preponderance of evidence presented at the hearing. The decision must be reached by a majority vote.
- The hearing panel will prepare a written decision, including the rationale, for its decision

**b. Review Results**

The Plan's medical director shall report the decision of the hearing panel to the credentialing department within five business days of the date of the hearing. The credentialing staff shall notify the practitioner by certified mail, return receipt requested, within 10 calendar days of receiving notification from the medical director of the hearing panel's decision and rationale.

**5. Additional Review Processes**

If additional review processes beyond the initial hearing are mandated by state regulation or accreditation organizations, and there is not a specified process to follow in such mandate, the following shall apply:

- A new hearing panel will be appointed. Practitioners who are given this additional level of review will be notified of this in the written communication sent to them after the formal hearing described above. To exercise their right to this additional review the practitioner must make this request in writing within 30 calendar days of receipt of the results of the formal hearing.
- This panel will consist of at least three qualified individuals, none of whom have prior involvement with the determinations related to the case or are in economic competition with the practitioner requesting the further review. Additionally, at least one of the panel members will be a participating practitioner who is not otherwise involved in medical management and is a clinical peer of the practitioner making the appeal. The panel will be appointed by the Plan's medical director or designee. The practitioner may provide additional relevant information in writing to this hearing panel but will not be present. The hearing panel will meet within 45 calendar days of the credentialing department's receipt of the request for the additional review. All information from the prior proceedings will be reviewed by the panel along with any additional written information submitted by the practitioner. However, the appellate review body shall be held to the following standard of review.

#### **D. Standard of Review**

The appellate review body convened for any subsequent reviews after the initial hearing shall review the initial hearing panel report and all subsequent results and actions thereon. The appellate review body shall also consider any written statements submitted by the provider to determine whether the adverse determination was justified and was not arbitrary and capricious.

#### **E. Review Results**

The practitioner making the appeal will be notified by certified mail within 10 calendar days of the final determination. If, at the final level of appeal, the determination is made to uphold the adverse action, the practitioner and appropriate internal Plan departments will be notified of the action. Except in cases of immediate terminations (see Credentialing Policy #11) the action will be effective at 90 calendar days from the date of the determination.

#### **F. Reporting Final Adverse Actions**

We will report any final adverse actions in accordance with Credentialing Policy #12.

### **VI. Professional Review Action Related to Health Delivery Organizations (HDO's)**

Actions adverse to an HDOs participation in our programs or networks that are not based on concerns related to professional qualifications are not addressed in this section, except to the extent that such practices may have been determined to be unprofessional conduct or competence by the Credentialing Committee. Examples of such actions that are not addressed in this section are those related to network over capacity, or unsatisfactory business or billing practices. These are viewed as administrative actions.

An HDO may request a professional review action with our decision to terminate or reject an HDO from network participation that is based on quality or patient safety issues that affect or could adversely affect the health or welfare of a patient. Some examples are:

- A determination that an HDO affects or could affect adversely the health or welfare of a patient due to a review of credentialing criteria including but not limited to:
  - Failure to maintain accreditation
  - Credible information that patient safety concerns exist
  - Failure of the contracted HDO to meet the objectives of the corrective action plan relating to clinical quality (including but not limited to corrective action plans addressing credentialing criteria deficiencies)
  - Any action based on the quality or appropriateness of patient care (including, but not limited examples set forth herein). Examples include, but are not limited to
    - Lack of adequate oversight of patients while receiving care
    - Unacceptable conduct by staff members of the HDO, or failure to maintain patient safety standards as required by law

#### **A. Notice and Request for First-Level HDO Review**

##### **1. Notice**

Upon decision by the Credentialing Committee to terminate an HDO's participation, the credentialing staff will notify the HDO by certified letter of the decision.

- The notice will contain the reason for the decision, a statement that the HDO has the opportunity for an informal review/reconsideration of the decision, a statement that the entity has the right to submit additional information to us for informal review/reconsideration and a summary description of the review process (described below)
- The notice will also state that if the HDO wants an informal review/reconsideration, the HDO must submit, within the 30-calendar day period immediately following the date of receipt of the notice (unless otherwise required by state regulation), a written request to the credentialing department for a review of the decision, along with any additional information the HDO wants to be considered
- A request for an informal review/reconsideration shall not stay the effective date of the termination unless otherwise required by state law or regulation or by contract

For information regarding immediate terminations.

##### **2. Request for First-Level Review (Informal Review/Reconsideration)**

The HDO may request a first-level informal review/reconsideration of the Credentialing Committee's decision if the decision of the Committee is adverse to the provider.

This request must be in writing, sent by certified mail and be received by the credentialing department within the 30-calendar day period immediately following the date of the HDO's receipt of the certified letter from us (unless otherwise required by state regulation) with its determination based on the Credentialing Committee's results.

### **3. Meet-and-Confer**

If the contract between us and the HDO gives the entity a right to meet-and-confer with us as part of the contractually defined dispute resolution process, the HDO representative will so be advised at the time of notification of the determination and further advised that the entity may, within 30 calendar days of the date of mailing the notice request in writing a meet-and-confer with representatives of the Credentialing Committee. A meet-and-confer shall be an informal meeting between the HDO representative and two or more representatives of the Credentialing Committee designated by the Committee chair.

The chair may designate qualified individuals who are not members of the Committee to act as its representative for the purposes of the meet-and-confer. The HDO will be invited to present in an informal proceeding any information that it believes may have a bearing on the matter; and the representatives of the Committee will be free to ask questions of the HDO representative.

Following conclusion of the meet-and-confer, the representatives of the Credentialing Committee will recommend a disposition of the matter to the Committee at the Committee's next meeting, and the Committee will consider the recommendation and either sustain or set aside the termination or suspension of the HDO.

The HDO shall be informed of the results of the meet-and-confer after the information is presented to the Credentialing Committee and a reconsideration determination is made (as described below).

### **B. Alternative Dispute Resolution**

For HDOs that are terminated by a Credentialing Committee action, and whose contract does not give the right to a meet-and-confer, we may offer an alternative dispute resolution process prior to the informal hearing. This will be offered only when required by regulation or accreditation. This includes the right to consideration of all the information relevant to the determination by an authorized representative of the Plan who was not involved in the original determination. The HDO will be so advised at the time it is informed of the determination and further advised that it may, within 30-calendar days of the date of mailing the notice request in writing, an alternative dispute resolution.

The alternative dispute resolution shall be an informal meeting between the HDO representative and one or more authorized representatives of the Plan not involved in the original determination and appointed by the chair of the Credentialing Committee. The chair may designate any qualified individual to represent us. The practitioner will be invited to present in an informal proceeding any information believed to have a bearing on the matter; and the authorized representative of the Plan will be free to ask questions of the practitioner.

Following conclusion of the alternate dispute resolution, the representatives will recommend a disposition of the matter to the Credentialing Committee at its next meeting, and the Committee will consider the recommendation and either sustain or set aside the termination or suspension of the practitioner. The practitioner shall be informed of the results of the alternate dispute resolution after the information is presented to the Credentialing Committee and a reconsideration determination is made (as described below).

The HDO making the appeal may waive this level of appeal and proceed directly to the informal hearing; notification of this will be included with the letter advising the practitioner of its availability. Failure to request an alternate dispute resolution process will have no effect on any further determinations.

### **1. Process**

Any additional information submitted subsequent to the initial decision will be reviewed by the credentialing staff for informal review/reconsideration. The credentialing staff will review the information as the basis for the initial decision, along with any additional information submitted by the HDO and if appropriate, forward the matter including any additional information submitted by the HDO to the Credentialing Committee at its next meeting. No representatives of the HDO shall be present during the informal review/reconsideration. For initial determinations, if the information submitted by the HDO contains no new objective information, it may be presented in summary form.

### **2. First-Level Review**

As a reconsideration, any additional information submitted subsequent to the initial decision of the Credentialing Committee will be presented to the committee for its consideration. All of the conditions of Credentialing Policy #3 apply with regards to the Credentialing Committee. The Committee will review the information obtained during the credentialing process and the basis for its initial decision, along with any additional information submitted by the HDO. For those cases where a meet-and-confer process has occurred, the results of this will be available as well. This review may take place at the regularly scheduled Credentialing Committee meeting or at a special review meeting. The representatives of the HDO shall not be present during the review. We may have credentialing staff, network service representatives and legal representatives present for the first-level review as nonvoting members.

### **3. Review Results**

The Credentialing Committee shall report its decision on the first-level review (informal review/reconsideration) to the credentialing department within five business days of its decision. The credentialing staff shall notify the HDO by certified mail within 14 calendar days of the decision.

## **C. Second-Level Review Process**

### **1. Notice**

Upon notification that the informal review/reconsideration of a decision to terminate an HDO's participation of a professional review action was upheld by the CC, the credentialing staff will notify the entity by certified letter of the decision. The notice will:

- Contain the reason for the decision
- Where an HDO is eligible for formal appeal, a statement that
  - the HDO has the opportunity to submit additional information to us for formal appeal of the decision and

- a summary description of the formal appeal process described below
- State that if the HDO wants an appeal, the entity must submit, within the 30-calendar day period immediately following the date of receipt of the notice (unless otherwise required by state regulation)
  - a written request to the credentialing department for an appeal of the decision and
  - any additional information the HDO wants to be considered

A request for a formal appeal shall not stay the effective date of the termination, unless otherwise required by state law or regulation or by contract.

#### **D. Formal Hearing Upon Request**

As a second-level of review, the terminated HDO may request a formal hearing if the decision of the first-level review is adverse to the HDO. This request must be in writing and received by certified mail within the 30-day period immediately following the date of the HDO's receipt of the notice from us. If an HDO timely requests a hearing, the following procedures will be followed:

- The credentialing staff will notify the Plan's medical director and the Plan's legal counsel of the HDO's request for a hearing
- Hearing Panel—The Plan medical director or designee will select the members of the hearing panel. The hearing panel will be comprised of at least three individuals not involved in the original decision. Only hearing panel members not involved in the original decision may vote. No person with an economic interest in an entity in direct competition with the appealing HDO may serve on the hearing panel. At least one of the hearing panel members will be a participating practitioner with some experience with the type of HDO in question, but without any other role in network management. The hearing panel will be chaired by the Plan's medical director or designee who is entitled to vote and who is counted as a member of the hearing panel.
- Hearing Notice—Within 30 business days of receipt by us of a practitioner's request for a formal appeal, the credentialing staff will send a certified letter notifying the HDO of the date, time and place of the formal hearing. It will advise the representatives of the HDO that it may have its representative appear in person or by telephone. This letter will also summarize the hearing procedures and notify the HDO representative that he or she may appear with a legal representative or other designee before the hearing panel, and that the entity and its representatives have the right to:
  - have a record made of the proceedings, copies of which may be obtained by the practitioner upon payment of any reasonable charges associated with the preparation thereof
  - call, examine and cross-examine witnesses
  - present evidence determined to be relevant by the hearing panel regardless of its admissibility in a court of law
  - submit a written statement at the close of the hearing

- receive upon completion of the hearing, the written decision of the panel, including a statement of the basis for the decision

Such notice will also state that the HDO will forfeit its right to a hearing if the representative of the HDO fails to attend the hearing (either in person or by telephone) without good cause.

In advance of the hearing, the Credentialing staff will give each hearing panel member a copy of the denial letter originally sent to the applicable HDO. The panel members may also be provided with any other material deemed relevant us at or in advance of the hearing.

- Hearing Date—The hearing date will be not less than 30- nor more than 60-calendar days after the date of the notice given to the HDO of the date, time and place of the formal hearing or as otherwise agreed to by us and the affected practitioner.

### **E. Hearing Procedures**

The chairperson of the hearing panel, who is the medical director or his/her designee, will open the hearing by stating the purpose of the hearing and protocol of the hearing.

- During the hearing, the HDO representative will have the ability to exercise any or all of the rights as set forth in the **b.Revi** subsection above.
- Our representative will present the reasons for the decision to terminate the HDO
- The representative of the HDO will present reasons why its participation should not be terminated
- Before the close of the hearing, each side may briefly summarize its position for the hearing panel, if it chooses
- The maximum duration of the hearing will be two hours unless the chairperson of the hearing panel, in her or her discretion, determines that the hearing panel cannot reasonably be concluded in that time period.
- The hearing panel will meet privately after the hearing to reach a decision. Each voting member of the hearing panel will have one equal vote. The hearing panel will have the authority to uphold, reject or modify the original decision based on a preponderance of evidence presented at the hearing. The decision must be reached by a majority vote.
- The hearing panel will prepare a written decision, including the rationale, for its decision.

### **F. Review Results**

The Plan's medical director shall report the decision of the hearing panel to the credentialing department within five business days of the date of the hearing. The credentialing staff shall notify the HDO by certified mail, return receipt requested, within 10 calendar days of receiving notification from the medical director of the hearing panel's decision and rationale.

### **G. Additional Review Processes**

If additional review processes beyond the initial hearing are mandated by state regulation or accreditation organizations, and there is not a specified process to follow in such mandate, the following shall apply:



- A new hearing panel will be appointed. HDOs that are given this additional level of review will be notified of this in the written communication sent to them after the formal hearing described above. To exercise their right to this additional review the HDO must make this request in writing within 30 calendar days of receipt of the results of the formal hearing.
- This panel will consist of at least three qualified individuals, none of whom have prior involvement with the determinations related to the case or have an economic interest in an entity in direct economic competition with the HDO requesting the further review. Additionally, at least one of the panel members will be a participating HDO who is not otherwise involved in medical management and is a clinical peer of the HDO making the appeal. The panel will be appointed by the Plan's medical director or designee. The HDO may provide additional relevant information in writing to this hearing panel but will not be present. The hearing panel will meet within 45 calendar days of the credentialing department's receipt of the request for the additional review. All information from the prior proceedings will be reviewed by the panel along with any additional written information submitted by the HDO. However, the appellate review body shall be held to the following standard of review.

## **H. Standard of Review**

The appellate review body convened for any subsequent reviews after the initial hearing shall review the initial hearing panel report and all subsequent results and actions thereon. The appellate review body shall also consider any written statements submitted by the HDO to determine whether the adverse determination was justified and was not arbitrary and capricious.

## **I. Review Results**

The HDO making the appeal will be notified by certified mail within 10 calendar days of the final determination. If at the final level of appeal the determination is made to uphold the adverse action, the HDO and appropriate internal Plan departments will be notified of the action. Except in cases of immediate terminations (see Credentialing Policy #11). The action will be effective at 90-calendar days from the date of the determination.

## **VII. The CAQH Universal Credentialing DataSource**

The Council for Affordable Quality Healthcare (CAQH) Universal Credentialing DataSource is a Web-based service that streamlines the credentialing process and simplifies administration for physicians and other health care practitioners. CAQH, in collaboration with us and other health plans and health care organizations, developed Universal Credentialing DataSource to reduce the redundancy and administrative work associated with the credentialing process.

### **A. Types of Practitioners Included in This Service**

The service is available to Doctors of Medicine (MDs), Doctors of Osteopathy (DO), Doctors of Chiropractic (DCs), Doctors of Podiatric Medicine (DPMs), Doctors of Dental Science (DDS) and Doctors of Dental Medicine (DDM) and other types of allied health care practitioners.

## **B. The Benefits of This Service to Practitioners**

Benefits of this service to practitioners include the following:

- The service is a one-stop shop for credentialing submissions; practitioners only need to enter their credentialing information once for all initial and recredentialing events with us or any other participating organization
- The service is free of charge
- The credentialing application submission process includes sophisticated security and confidentiality procedures, including passwords and powerful 128-bit Secure Socket Layer (SSL) encryption; this is the same type of security features used in the banking industry
- CAQH will not disclose data to anyone without the practitioner's permission
- The Practice Administrator Module will help the practitioner's office staff enter information that may be redundant across multiple practitioners in a single practice location (such as practice location details, hospital privileges and malpractice policy information)

## **C. Universal Credentialing DataSource Contact Information**

The CAQH Help Desk provides telephone service support Monday to Friday, 5 a. m. to 5 p. m. to provide assistance with any questions the practitioner may have. The CAQH Help Desk can be contacted by calling **1-888-599-1771** or by e-mail at **help@caqh.geoaccess.com**. Practitioners may also contact Network Services Department at **1-800-933-6633** for assistance.