SIGNATURE CARE

2017 CREDENTIALING PLAN

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Section 1 Authority

Managed Care Services, LLC d/b/a Parkview Health Plan Services (HPS) is owned by Parkview Health and Parkview Hospital and manages Signature Care which is a PPO network. The Board of Managers of HPS (Board of Managers) authorizes, endorses and supports the proactive ongoing credentialing process of selecting and evaluating Professionals and Providers who provide care and services to Signature Care members. The Board of Managers delegates full authority to conduct credentialing activities, approvals and denials of applicants to the HPS credentialing staff (Staff) and the Credentials Committee (Committee) as set forth in this Credentialing Plan (Plan).

It is the intent of HPS that this Plan meets or exceeds the Standards and Guidelines for Organization Certification in Credentialing (OC-CR) as published by the National Committee for Quality Assurance (NCQA). Therefore, throughout this Plan there are references to specific OC-CR Credentialing Standards (CR).

Section 2 Purpose

The purpose of the Committee is to provide an ongoing process to evaluate and verify the qualifications of all initial applicants and recredentialing applicants. The Committee shall exercise reasonable care to select, approve and retain Professionals/Providers who are shown to be qualified, have acceptable service levels, and meet the minimum credentialing criteria stated in the Plan.

Section 3 Scope

The Board of Managers authorizes the Staff and Committee to carry out the credentialing functions as defined by the Plan. The Committee will review, evaluate, and approve or deny the credentials of all Providers and all individual MDs, DOs, DPMs, DDSs, DCs and other licensed Allied Health Care Professionals (this excludes delegated Professionals, Professionals providing call coverage only and hospital based Professionals in anesthesiology, emergency medicine, neonatology, radiology, pathology, behavioral health care, hospitalists and telemedicine) except those submitting Clean Applications.

Section 4 Responsibilities Of The Credentials Chair

1. To review all applicant files and approve those deemed as Clean Applications for credentialing as Signature Care Professionals/Providers.
2. To make recommendations to the Board of Managers for all approved or denied applications and for all Plan amendments.
3. To consult with Staff regarding credentialing applications or issues when required.
4. To oversee the proceedings of Committee meetings and provide a tie-breaking vote if necessary.

Section 5 Responsibilities Of The Credentials Committee

1. To review and approve or deny applicant files, other than Clean Applications, for credentialing as Signature Care Professionals/Providers.

2. To provide reconsideration and/or an appeal process for applicants who have been denied access or continued participation.

3. To provide, approve and maintain written credentialing criteria.

4. To annually review the Plan and recommend appropriate changes, as necessary, to the Board of Managers.

5. To review delegated network plans regarding their credentialing process.

Section 6 Membership

The Committee will include representation from a range of participating Professionals. The Board of Managers shall approve all Committee members, including the Credentials chairperson (Chair). The Chair is generally a non-voting Committee member, holding only a tie-breaking vote. Other persons may attend meetings at the invitation of the Chair; however, such persons shall not have voting rights. The Committee will meet monthly or as business needs dictate. The Medical Director of HPS (Medical Director) will serve as a non-voting advisory member to the Committee and provide review or approval for applications when the Chair must recuse himself or is unavailable. Committee and Staff members shall be indemnified by HPS for their credentialing activities pursuant to the Plan.

Section 7 Manner of Acting

1. A total of three (3) voting members of the Committee shall be required for valid business transactions brought to Committee meetings with outcomes of all voting decisions to be determined by the majority.

2. Complete and accurate minutes of all Committee meetings shall be prepared and maintained by Staff. The minutes will contain names of Committee members present and absent, the meeting date and will also reflect major decisions, recommendations and the status of activities in progress. Applicable reports and supporting data will be appended as necessary.

3. The Committee must approve applications that do not meet the Clean Application criteria before the applicant may enter into a Participating Provider Agreement.

4. The Committee will maintain and restrict access of information to Committee members, to Staff and to those specific individuals designated by the Chair and/or the Medical Director.

Section 8 Statement of Confidentiality

It is the intention of the Plan that the credentialing process be protected under Indiana and federal peer review laws. The Committee shall act as a peer review committee. All proceedings of the Committee shall remain confidential, and all communications with the Committee shall be privileged. Individuals engaged in credentialing activities shall maintain the confidentiality of information. In particular, information supplied with and on the application shall remain confidential. The Committee members shall be required to execute a Parkview Health confidentiality statement annually.

Section 9 Conflict of Interest

No person may participate in the review and evaluation of any applicant with whom they have been professionally involved or when their judgment may be compromised. The Committee shall be required to execute Parkview Health financial incentive / conflict of interest statements annually.

Section 10 Plan Evaluation

The Plan will be reviewed annually and revised as necessary by the Board of Managers, with input and assistance from the Staff and Committee. The Board of Managers must approve all revisions.

Section 11 Anti-Discrimination

The Committee shall not make initial credentialing or recredentialing decisions based on race, ethnicity/national identity, gender, age, sexual orientation, religion, creed, prototype procedures (e.g. abortions), nor type of patients (e.g. Medicaid) in which the Professional/ Provider specializes.

To ensure compliance with the non-discrimination clause, the following affirmative statement will be included with monthly business: *"I, as the Credentials Chair in the decision-making process, assure that credentialing and re-credentialing is conducted in a non-discriminatory manner. The formal selection and retention criteria by the Committee does not discriminate against health care Professionals/Providers based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, prototype procedures (e.g. abortions), nor type of patients (e.g. Medicaid) in which the Professional/Provider specializes."* (CR1)

Section 12 Delegated Credentialing

Signature Care credentialing may be delegated by contract to one or more entities, provided a delegated entity's credentialing plan meets or exceeds the minimum criteria in this Plan. The processes outlined in this Plan define the Signature Care credentialing process. Each delegated entity's credentialing process must also support the minimum criteria in this Plan. The Committee shall review each delegated entity's application forms and credentialing plan to ensure that they meet or exceed the minimum criteria set forth in Section 13. The Committee shall also adopt a checklist of processes each delegated

entity must follow. In addition, the delegated entity's Credentialing Committee must be constructed to meet state and federal requirements for peer-review. The delegated entity must agree to permit the Committee access to the delegated entity's credentialing files and their credentialing committee minutes, or a written summary of such minutes, for oversight of the Signature Care credentialing process.

The Committee has the ultimate authority for credentialing Professionals/Providers in a delegated arrangement. The Board of Managers retains the right to approve new Professionals/Providers and to terminate or suspend Professionals/Providers. (CR11. Element C) The Committee may, at its sole discretion, review any credentialed Professional/Provider as well as all exceptions granted by the delegated entity, as the Committee deems appropriate. Delegation may be removed from an entity upon recommendation of the Committee with approval from the Board of Managers.

The Committee, with the assistance of Staff, shall review the delegated entity's application and credentialing plan at least annually to assure that the delegated entity's credentialing plan continues to meet or exceed the minimum credentialing criteria in this Plan and contains the processes listed in the checklist adopted by the Committee. The Committee may also direct Staff to conduct audits, as may be reasonably required, to assure the delegated entity's compliance with its credentialing plan. This annual review and audit process may be conducted by questionnaire provided by Staff to the delegated entity and to which the delegated entity must respond.

A delegated entity must notify Signature Care within 10 (ten) business days of any Professional/Provider changes in status, including but not limited to:

1. Termination
2. Resignation
3. Changes in privileges
4. Placement on license probation or facility probation
5. Suspension or exclusion from Medicare/Medicaid
6. Loss of Drug Enforcement Administration (DEA) or Controlled Substance Registration (CSR), criminal conviction of any felony or, effective January 1, 2008, any misdemeanor related to controlled substances, illegal drugs, insurance or healthcare fraud or abuse, or violence. Conviction includes a plea or verdict of guilty or a conviction following a plea of *nolo contendere*.
7. Other disciplinary action

Consequences for a delegated entities' failure to perform can range from the development of corrective action plans, to additional audits of compliance by HPS, to revocation of the delegation agreement. (CR11, Factor 6)

The delegated entity shall not make initial credentialing or recredentialing decisions based on race, ethnicity/national identity, gender, age, sexual orientation, religion, creed, prototype procedures (e.g. abortions) or type of patients (e.g. Medicaid) in which the Professional/ Provider specializes. To ensure compliance with the non-discrimination clause, the following affirmative statement will be included with monthly business*: "I, as the Credentials Chair in the decision-making process, ensure that credentialing and re-credentialing is conducted in a non-discriminatory manner. The formal selection and retention criteria by the committee does not discriminate against health care Professionals/Provider based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, prototype procedures (e.g. abortions), or type of patients (e.g. Medicaid) in which the Professional/ Provider specializes."*

Section 13 Minimum Criteria for Credentialing

The Committee has the authority to waive any qualification for participation upon determination that said waiver is consistent with good medical practice and the provision of patient care. This shall be done on an individual basis and reported to the Board of Managers as a waiver of qualification. The rationale for this decision will also be reported.

Each applicant shall have a responsibility of producing timely and adequate information for a proper evaluation of competence, character, ethics and other qualifications, and for resolving any doubt about such qualifications. The required qualifications of an individual applicant are listed below. Each applicant will maintain compliance with all criteria as a condition of continued participation. Any applicant not meeting the following requirements need not apply, as the application will be deemed incomplete by the Staff and will not be processed or acted upon by the Committee.

Re-credentialing must occur every 36 months.

1. Minimum qualifications for Professional application.

    a. Accurate completion of a CAQH application form.

    b. Graduation from a recognized school for the appropriate profession (i.e. medical school, dental school, podiatry school, chiropractic college or college as applicable for Allied Health Care Professional certifications).

    c. Educational Commission for Foreign Medical Graduates (ECFMG), if applicable.

    d. Successful completion of residency training appropriate for the time and specialty of practice, or current or previous board certification in practicing specialty by specialty boards recognized by the American Board of Medical Specialties or the American Medical Association. Exceptions for General Practitioners include graduation from medical school prior to 1978, with completion of one (1) year internship, and practices as a General Practitioner.

e. Current, active, unrestricted state(s) license(s) to practice, as appropriate. A practitioner may be on probation by the Indiana Health Professions Bureau for alcohol or other drug related abuse, provided the practitioner is in compliance with treatment as prescribed by the Indiana State Medical Association Physician Assistance Program or in a comparable status and program in another state, all subject to approval by the Committee. Documentation of compliance and participation with the Program's treatment plan is required.

f. No current Medicare/Medicaid sanctions.

g. Work history for the last 10 (ten) years or from initial licensure if less than 10 (ten) years. All lapses of 180 days or more require an explanation.

h. Current evidence for professional liability insurance coverage of $250,000 / $750,000, showing qualification as a Professional in the Indiana Patient Compensation Fund (IPCF) or professional liability insurance coverage of at least $1,000,000/$3,000,000 or at such higher levels as may be required by law.

i. Have current clinical admitting privileges in good standing at a network facility. In lieu of admitting privileges, a primary care Professional may have an agreement in place to admit through an in-network hospitalist program. . Certain specialties, as dictated by community standards, are not required to obtain admitting privileges given their scope of care and therefore are considered exempt from this criteria.

j. Acceptable National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB) reports.

k. Current, unrestricted CSR and DEA certification, if required by state.

l. Malpractice claims history included in the application, that contains a detailed report of each liability claim that is open, has been opened, pending, settled, arbitrated, mediated, litigated, or has been closed in the previous five (5) years. The malpractice claim history must be acceptable to the Committee after its review of frequency, severity, patterns and trends.

m. Disclosure of the reasons for any inability to perform the essential functions of the position, with or without accommodation.

n. Disclosure of past or present illegal use of drugs or alcohol and of treatment for chemical dependency.

o. History of loss of license, restrictions, or disciplinary actions. This history must be acceptable to the Committee after its review of frequency, severity, patterns and trends.

p. For initial credentialing, criminal history with no convictions for any felony and, effective January 1, 2008, no convictions within the preceding six years for misdemeanors related to controlled substances, illegal drugs, insurance or healthcare fraud or abuse, or violence (unless the conviction was prior to initial

professional licensure). For renewal credentialing, criminal history with no convictions for any felony and no convictions after January 1, 2008, for misdemeanors related to controlled substances, illegal drugs, insurance or healthcare fraud or abuse, or violence unless the misdemeanor conviction occurred prior to initial credentialing. Conviction shall include a plea or verdict of guilty or a conviction following a plea of *nolo contendere*.

q. Disclosure and information from licensure agencies, managed-care networks, insurers, hospitals, facilities or other healthcare practitioners that call into question a Professional's unethical or unprofessional behavior, clinical competency or disruptive behavior which may impede the provision of quality healthcare.

r. Disclosure and information concerning any past denial, non-renewal, or cancellation of malpractice insurance.

s. Disclosure and information concerning any suspension, restriction, loss of privileges or termination by any managed-care plan or hospital.

t. Collaborative Agreement with a participating physician Professional for Nurse Practitioners, Clinical Nurse Specialists and Certified Nurse Midwives.

u. Physician Assistants (PA) must have a supervisory agreement in writing, where all delegated tasks are outlined by the supervising physician. Indiana Code 25-27.5-5-2(F)

2. <u>Minimum qualifications for Provider application:</u>

a. Current, active, unrestricted state license to provide services as appropriate to type of Provider.

b. Federal or State Licensing Certificate for diagnostic services (radiology, CLIA), if applicable.

c. Medicare certificate or number, if applicable.

d. No current Medicare/Medicaid sanctions.

e. Current evidence of professional and, if applicable, general liability insurance coverage of $250,000/$750,000, showing qualification as a Provider in the Indiana Patient Compensation Fund (IPCF) or professional liability insurance coverage of at least $1,000,000/$3,000,000, or at such levels as may be required by law.

f. Accreditation Certificate or State Board of Health survey, if applicable. (CR10)

g. DEA Certificate, if applicable.

h. CSR Certificate, if applicable.

i. Pharmacy Permit, if applicable.

j. Acceptable HIPDB report.

k. History of loss of license restrictions or disciplinary actions. This history must be acceptable to the Committee after its review of frequency, severity, patterns and trends.

l. For initial credentialing, criminal history with no convictions for any felony and, effective January 1, 2008, no convictions within the preceding six years for misdemeanors related to controlled substances, illegal drugs, insurance or healthcare fraud or abuse, or violence. For renewal credentialing, criminal history with no convictions for any felony and no convictions after January 1, 2008, for misdemeanors related to controlled substances, illegal drugs, insurance or healthcare fraud or abuse, or violence unless the misdemeanor conviction occurred prior to initial credentialing. Conviction shall include a plea or verdict of guilty or a conviction following a plea of *nolo contendere.*

m. Disclosure and information concerning any suspension, restriction, loss of privileges or termination by any managed-care plan or hospital.

Section 14 Submission of Application

Applications through the Council for Affordable Quality Healthcare (CAQH) are the preferred format. However, delegated entities may choose to use their own application as outlined in their credentialing plan. Applications are to be submitted to the HPS Credentialing Department as outlined below.

1. Completed, legible application.

2. Signed attestation by the applicant.

3. Applicants will be notified by Staff via certified mail, of information obtained during the credentialing process that substantially varies from the information the applicant submitted. In addition, applicants have both the right and the obligation to correct erroneous information by submitting written clarification to Staff within 30 (thirty) calendar days. However, if the corrected application nonetheless contains a material misstatement or omission, or if, upon review after correction, the Committee concludes that a misstatement or omission had been material and had been intended to mislead staff and/or the Committee, the Committee shall consider the application to fail to meet minimum criteria for credentials and it shall be deemed voluntarily withdrawn from consideration. Staff will document when responses are received and place them in the applicant's credentialing file.

4. If a reply is not received within the stipulated time, a copy of the original letter will be sent to the applicant every 30 (thirty) calendar days. If no reply is received, upon the 181st calendar day a letter will be sent to applicants informing them that the credentialing application fails to meet minimum criteria for credentials and it is deemed voluntarily withdrawn from consideration.

5. All information will be handled in a confidential manner and in compliance with Indiana Code 34-30-15.

6. Applicants who have been denied credentialing by Signature Care or have had their applications deemed voluntarily withdrawn because of a material omission or misstatement or have voluntarily relinquished their credentials must wait three (3) years before submitting a new application.

7. Staff will notify an applicant of any deficiencies in the application within 30 business days. Staff will also notify the applicant concerning status of the application after 60 days, and every 30 days thereafter until a final credentialing decision is made.

Section 15 Applicant Rights

1. Applicants have the right to review non-peer review protected information obtained from any outside source in their credentialing file.

2. Applicants have the right to correct erroneous information as specified in Section 14 - 3.

3. Applicants have the right to be informed of the status of their applications upon request.

4. Applicants have the right to withdraw their applications.

5. Applicants have a right to notification of these rights.

Section 16 Appropriate Documentation to Perform Primary Source Verification (CR1)

1. Verbal verification – Staff must date, sign or initial verification, and obtain name and credentials of authorized person providing information.

2. Written verification – in the form of a letter or report, dated within the required verification time frame. Staff must date and sign or initial verification.

3. Internet or electronic verification – Staff must sign or initial and note the date of retrieval or receipt of verification.

Section 17 APPROVED Sources for Primary Source Verification

1. State licensing boards (for Professional/Provider license and Controlled Substance Registration)

2. Drug Enforcement Agency

3. Individual Boards of the American Board of Medical Specialties or an approved ABMS source

4. American Osteopathic Association physician profile report

5. Royal College of Physicians and Surgeons of Canada

6. Boards holding a reciprocity agreement with the American Board of Family Medicine
7. Educational institution or institution's approved verification source (for graduate degrees and/or certifications)
8. Educational Commission for Foreign Medical Graduates
9. Residency and fellowship training programs
10. American Medical Association Physician Master File
11. Certificate of Insurance or professional liability carrier
12. Indiana Department of Insurance
13. NPDB and HIPDB reports
14. CAQH for sanction monitoring
15. Criminal background check organizations

Section 18 Initial Credentialing Primary Verification

Primary verification of the following requirements must be conducted no more than 180 calendar days prior to the Committee decision:

1. All current medical licenses
2. Have current clinical admitting privileges in good standing at a network facility. In lieu of admitting privileges, a primary care Professional may have an agreement in place to admit through an in-network hospitalist program. . Certain specialties, as dictated by community standards, are not required to obtain admitting privileges given their scope of care and therefore are considered exempt from this criteria.
3. Current DEA and CSR, as applicable.
4. Board Certification
5. Residency training, if not board certified, dental school graduation, completion of specialty training, as applicable
6. Fellowship training, if not board certified
7. NPDB and HIPDB reports
8. Review for sanctions by Medicare and Medicaid.

Section 19 Initial Credentialing Process for Professionals

The following outline represents the credentialing process:

Responsible Party	Responsibilities
Signature Care	Sends the applicant a letter, which includes a list of the applicant's rights, directs the applicant to complete an application through the CAQH and to grant Signature Care access to the application. Applicant Completes application and provides information to Signature Care so online application can be retrieved.
Staff	Staff will retrieve, date, and verify online CAQH application for completeness. If application is incomplete, Professional will be notified.
Staff	Performs primary source verification of current board certification (if not board certified, education/training), Medicare/Medicaid sanction history, any disciplinary action, NPDB and HIPDB queries, current DEA and CSR, hospital privileges, and all active medical licenses. Also verifies current liability insurance coverage and acceptable work history.
Staff	Prepares, prior to the next scheduled meeting of the Committee, a summary for each applicant whose complete documentation and verification exists.
Chair	Performs a qualitative review of each application, determining those that will be deemed as a Clean Application. The credentialing date of the Clean Applications will be the date they were approved by the Chair or Medical Director.
Staff	Prepares a report and recommendation to the Committee for unclean applications, which must be reviewed by the Committee. Presents Clean Applications approved since the previous Committee meeting for informational purposes.
Committee	Reviews each application forwarded to it, evaluates the credentials, and makes a determination of the applicant's status. This must occur within 180 calendar days of the Applicant’s signed attestation. The applicant’s credentialing date is the date of the Committee approval.
Signature Care	Provides written notification of status to the applicant within 60 calendar days and to the Board of Managers at their next meeting.
Signature Care	Credentialed Professionals may be listed in the Signature Care Directory, if they choose and if appropriate, under their specified specialty or subspecialty. Some subspecialties are mapped to the appropriate specialty for listing in Signature

Care Directory. If Professionals have a number of specialties or subspecialties they will only be listed once in the Directory.

Section 20 Initial Credentialing Process for Providers

The following outline represents the credentialing process:

Responsible Party	Responsibilities
Staff	Sends the authorized representative an application with cover letter and instructions.
Applicant	Returns complete application within 14 calendar days of signing application and copies of all applicable credentials.
Staff	Dates application upon receipt and verifies the contents for completeness. Notifies applicant of incomplete application and requests missing information
Staff	Reviews amount and dates of coverage for liability insurance, Medicare/Medicaid sanctions history, HIPDB query, current DEA, CSR, accreditations, certifications and licenses as applicable.
Staff	Prior to next scheduled meeting of the Committee prepares a file for each Provider with complete documentation.
Chair	Performs a qualitative review of each application determining those that will be deemed as a Clean Application. The credentialing date of the Clean Application will be the date it was approved by the Chair or Medical Director.
Staff	Prepares a report and recommendation to the Committee for unclean applications, which must be reviewed by the Committee. Presents Clean Applications approved since the previous Committee meeting for informational purposes.Committee Reviews each application forwarded to it, evaluates the credentials and makes a determination of the Provider's status. The Provider's credentialing date is the date of Committee approval.
Signature Care	Provides written or electronic notification of status to the Provider within 60 calendar days and to the Board of Managers at its next meeting.

Section 21 Recredentialing Primary Verification

Primary verification of the following requirements must be conducted no more than 180 calendar days prior to Committee decision.

1. All current medical licenses

2. Have current clinical admitting privileges in good standing at a network facility. In lieu of admitting privileges, a Professional may have an agreement in place with another participating Professional that has in-network admitting privileges or, in the case of primary care Professionals, have an agreement in place to admit through an in-network hospitalist program. Specialists who do not have clinical admitting privileges must have an agreement in place with another participating Professional who shares a similar scope of practice and has active network admitting privileges. Certain specialties, as dictated by community standards, are not required to obtain admitting privileges given their scope of care and therefore are considered exempt from this criteria.

3. Current DEA and CSR, as applicable.

4. Board certification. If a previously verified board certification used, to verify education and training expires, it is not required to verify education and training. (CR 6)

5. NPDB and HIPDB reports

6. Review for sanctions by Medicare and Medicaid

A Professional's/Provider's participation within the Signature Care network cannot extend beyond the 36th month of the current appointment without participating in the recredentialing process. Failure to complete the recredentialing process by the end of the 36th month will result in expiration of credentialing status and termination from the network. The only exceptions to this practice are for Professionals on military assignment, maternity leave or sabbatical. If the Professional/Provider wants to continue in the network after the 36th month, they must start as an initial applicant. (CR7)

Section 22 Recredentialing Process For Professionals

Once applicants become members of Signature Care, they must be recredentialed at least every 36th months. The following outline represents the recredentialing process:

Responsible Party	Responsibilities
Staff	Sends the applicant a letter, which includes a list of the Recredentialing Applicant's rights, directs the applicant to complete an application through the CAQH and to grant Staff access to the application. Staff will retrieve online CAQH application.
Applicant	Completes application and provides information to Staff so online application can be retrieved.
Staff	Dates application upon retrieval and verifies the contents for completeness. If application is incomplete, Professional will be notified.
Staff	Performs primary source verification of current board certification (if not board certified, education/training),

	Medicare/Medicaid sanction history, any disciplinary action, NPDB and HIPDB queries, current DEA and CSR, hospital privileges, and all active medical licenses. Also verifies current liability insurance coverage and acceptable work history. Chair Performs a qualitative review of each application, determining those to be deemed as Clean Applications. The credentialing date will be the date approved by the Chair or Medical Director.
Staff	Presents Clean Applications approved since the previous Committee meeting. Prepares a report and recommendations for applications to be reviewed by the Committee.
Committee	Reviews each application received, evaluates the credentials and makes a determination of the applicant's status. This must occur within 180 calendar days of the applicant's signed attestation. The applicant's recredentialing date is the date of Committee approval.
Signature Care	Provides written notification of approval or denial status to the Board of Managers at its next meeting.
Signature Care	Credentialed Professionals may be listed in the Signature Care Directory, if they choose and if appropriate, under their specified specialty or subspecialty. Some subspecialties are mapped to the appropriate specialty for listing in Signature Care Directory. If Professionals have a number of specialties or subspecialties, they will only be listed once in the Directory.

Section 23 Recredentialing Process For Providers

A Provider for Signature Care must be re-credentialed at least every 36 months. The following outline represents the re-credentialing process:

Responsible Party	Responsibilities
Staff	Sends the authorized representative an application with cover letter and directions prior to the recredentialing date.
Applicant	Returns complete application within 14 calendar days of signing application and copies of all applicable credentials.
Staff	Dates application upon receipt of the recredentialing application, and verifies the contents for completeness. Notifies applicant of incomplete application and requests missing information.

Staff	Reviews amount and dates of coverage for liability insurance, Medicare/Medicaid sanctions history, HIPDB query, current DEA, CSR, accreditations, certifications and licenses, as applicable.
Chair	Performs a qualitative review of each application, determining those to be deemed as Clean Applications. The credentialing date will be the date approved by the Chair or Medical Director.
Staff	Presents Clean Applications approved since the previous Committee meeting. Prepares a report and recommendations for applications to be reviewed by the Committee.
Committee	Reviews each application received, evaluates the credentials and makes a determination of the Provider's status. This must occur within 180 calendar days of the applicant's signed attestation. The Provider's recredentialing date is the date of Committee approval.
Chair	Provides written notification of approval or denial status to the Board of Managers at its next meeting.

Section 24 Denial of Initial Application or Recredentialing Application

Initial and recredentialing applications will be denied if the applicant fails to meet minimum criteria for credentialing and may be denied based upon one or more of the following reasons, if they present concerns about the clinical competency of a Professional/Provider or the patient care provided by a Professional/Provider:

1. Experimental treatment in practice.
2. Suspension or termination from any managed-care plan.
3. Actions by licensure agencies, other health care providers, managed-care networks, or insurers, which call into question the competency of a Professional/Provider.
4. Arrests based on criminal allegations.
5. A medical malpractice history that, after explanatory documentation, is not acceptable to the Committee.
6. History of loss of license, restrictions, or disciplinary actions that, after explanatory documentation, is not acceptable to the Committee.
7. Any other activities or practices that present concerns about the clinical competency of a Professional/Provider or the patient care provided by a Professional/Provider.

Section 25 Precautionary Suspension

Any three (3) of the following five (5) shall have the authority to suspend a Professional/ Provider from the network whenever failure to take such action may result in imminent danger to the health and/or safety of an individual:

1. Committee Chair
2. Board of Managers member
3. Medical Director
4. Committee member
5. Executive Director of HPS (shall include any other person, regardless of title, appointed by Parkview Health to be the senior management leader of HPS's business)

The precautionary suspension shall become effective immediately upon imposition and shall be reported to the Chair, Board of Managers Chair, Medical Director and Executive Director of HPS. The suspended Professional/Provider shall assign the responsibility for the care of the suspended Professional's/Provider's patients in the hospital and/or the office to another network Professional/Provider with appropriate clinical privileges.

Within a reasonable time, not to exceed 96 hours for the imposition of a precautionary suspension, an ad hoc committee of at least three (3) active members of the Committee and/or the Board of Managers shall be appointed by the Chair of the Committee. This committee shall convene for the purpose of reviewing the precautionary suspension. This ad hoc committee shall be composed of no Committee member who is in direct competition with the affected Professional/Provider or who has actively participated in the precautionary suspension. This ad hoc committee shall make a recommendation to the Committee at its next scheduled meeting for the termination or continuance of the precautionary suspension.

If, as a result of such ad hoc committee review and recommendation, the Committee does not terminate the precautionary suspension, the precautionary suspension will continue and the affected Professional/Provider shall be entitled to the procedural rights of the Appeals/Due Process and Fair Hearing Process as set forth in this Plan. (Section 27 and Section 28) The terms of the precautionary suspension as continued or as modified by the Committee shall remain in effect until the appeals/due process and fair hearing process are completed.

Section 26 Change in Status/ Relinquishment, Suspension or Revocation

After credentials have been granted, each credentialed Professional and Provider must maintain compliance with all credentialing criteria as a condition of continued Signature Care participation. Failure to do so may result in relinquishment, suspension or revocation of credentialing status.

Relinquishment

Professionals/Providers who have been granted credentials with an uncorrected material misstatement or omission on the application form which is subsequently discovered by Staff or the Committee will not have met the minimum credentialing criteria/qualifications of the Plan and will be deemed to have voluntarily relinquished their credentialing status. The changes in Professional/Provider status described in the items listed below constitute a failure to meet the minimum objective requirements for participation or continued participation and will also be deemed an automatic voluntary relinquishment of the Professional's/Provider's credentialing status. Relinquishments of credentials shall be effective without action by the Committee and there shall be no appeal right.

1. Failure to maintain malpractice insurance in accordance with Signature Care specifications beyond temporary lapses not to exceed 30 days.
2. Suspension or exclusion from Medicare and/or Medicaid.
3. Failure to maintain current active unrestricted status of DEA or CSR, as applicable.
4. Criminal conviction of any felony or, effective January 1, 2008, any misdemeanor related to controlled substances, illegal drugs, insurance or healthcare fraud or abuse, or violence. Conviction includes a plea or verdict of guilty or a conviction following a plea of *nolo contendere*.
5. Refusal to execute a Participating Provider Agreement.
6. Termination of the Participating Provider Agreement.

<u>Automatic Suspension</u>

The changes in Professional/Provider status described listed below will result in automatic suspension of the credentialing status.

1. Failure to maintain current, active, unrestricted status of Professional/Provider license in any states in which they actively practice.
2. Abandonment of practice.
3. Physical or emotional impairment to their ability to practice medicine.

The affected Professional/Provider shall be notified of the automatic suspension in writing via certified mail, by any one of the following:

a) Committee Chair

b) Board of Managers Chair

c) Medical Director

d) Executive Director of HPS (shall include any other person, regardless of title, appointed by Parkview Health to be the senior management leader of HPS's business)

Such automatic suspension shall be deemed an interim precautionary step in the quality improvement and professional review activities related to the ultimate professional review action that may be taken with respect to the suspended Professional/Provider. It is not a completed professional review action in and of itself. The suspended Professional/ Provider shall assign the responsibility for the care of the suspended Professional's/ Provider's patients in the hospital and/or office to another network Professional/Provider, with appropriate clinical privileges..

The Committee shall review any automatic suspension at its next scheduled meeting. Within 30 calendar days of the meeting, the suspended Professional/Provider shall be advised of the status of the automatic suspension via certified mail. If the Committee does not terminate the automatic suspension, the automatic suspension will continue. The affected Professional/Provider shall be entitled to the procedural rights of the Appeals/Due Process and Fair Hearing Process as set forth in this plan. (Section 27 and Section 28) The terms of the automatic suspension, as continued or modified by the Committee, shall remain in effect until the Appeals/Due Process and the Fair Hearing Process are complete.

<u>Other Suspension or Revocation</u>

Any change in status with respect to the items listed below may, after consideration by the Committee, result in a suspension or revocation of credentials if the Committee determines that the Professional/Provider no longer meets the minimum criteria/qualifications of the Plan. The affected Professional/Provider shall be entitled to the procedural rights of the Appeals/Due Process and Fair Hearing Process as set forth in this plan. (Section 27 and Section 28) The revocation or the terms of the suspension, as continued or modified by the Committee, shall remain in effect until this Appeals/Due Process and the Fair Hearing Process are complete.

1. Engagement in conduct that:

    a. violates standards of ethical conduct governing the practice of medicine for which they are potentially subject to discipline, if applicable.

    b. otherwise subjects the Professional/Provider to being censured.

    c. subjects the Professional/Provider to investigation with respect to any of the above stated conduct.

2. Documentation of inappropriate utilization of medical resources, either excessive or inadequate.

3. Documentation of substantiated quality problems.

4. Repeated and substantial complaints from patients, institutions, peers or Allied Health Care Professionals.

5. Treatment of medical, surgical, cognitive, psychiatric, or substance abuse problems that could adversely affect patient care.

6. Non-compliance with an impaired physician's program.

7. Failure to maintain compliance with any other minimum credentialing criteria/qualifications of the Plan.

8. Any cause for denial of credentials listed in Section 24.

As a requirement of continued network participation, it is the responsibility of the participating Professional/Provider to inform Signature Care promptly of any change compliance with credentialing criteria, with the following being reported within 96 (ninety-six) hours:

1. Change in Medicare and/or Medicaid Professional/Provider status, suspension or exclusion.

2. Any change in status of hospital privileges, state license, state controlled substance certificate, or DEA certification, if applicable.

3. Cancellation of professional liability insurance.

4. Physical or emotional impairment to their ability to practice medicine.

5. Treatment of medical, surgical, cognitive, psychiatric, or substance abuse problems that could adversely affect patient care.

6. Non-compliance with an impaired physicians program.

7. Indictment based on any criminal charges or allegations that could lead to a conviction for any felony or for a misdemeanor related to controlled substances, illegal drugs, insurance or healthcare fraud or abuse, or violence.

Failure to provide notification may also result in revocation of credentialing status.

Section 27 Appeals / Due Process

If a Professional/Provider has been denied approval or renewal for credentialing/ re-credentialing, or is under an automatic suspension or precautionary suspension, or had their credentials revoked, a reconsideration/appeal process is available to the Professional/Provider. There is no appeal for actions that are deemed to be the voluntary withdrawal of credentialing status by the Professional/Provider or for automatic voluntary relinquishment of credentialing status by the Professional/Provider. The following outline represents this process.

Responsible Party **Responsibilities**

Chair	Notifies Professional/Provider, via certified mail, of denied participation decision, or continued automatic suspension or precautionary suspension. A copy of the appeals process will also be included in this mailing.
Applicant	May request reconsideration from the Committee within 30 calendar days of notice. Failure to request reconsideration within the 30 calendar day time period will result in termination of the Professional's/ Provider's appeal process.
Committee	Meets and may reverse decision based on additional information, or may uphold decision. The Professional/ Provider will be notified via certified mail of the Committee's decision.

Section 28 Fair Hearing Process

If the Committee upholds the non-participation, automatic suspension, precautionary suspension or revocation decision, the Professional/Provider is entitled to appeal to the Board of Managers within 30 calendar days of notification of the Committee's action. The following outline represents the Fair Hearing Process used when an appeal is made. The Board of Managers will designate one of the following processes to be utilized for the hearing:

1. Before an arbitrator who is mutually acceptable to the Professional/Provider and the Board.
2. Before a hearing officer who is appointed by the Board, and who is not in direct economic competition with the Professional/Provider involved.
3. Before an ad hoc committee (a panel of individuals) appointed by the Board and not in direct economic competition with the Professional/Provider involved.

The Professional/Provider is entitled to the following rights:

1. To have a record made of the proceedings.
2. To call, examine and cross-examine witnesses.
3. To present evidence determined to be relevant by the arbitrator, hearing officer or ad hoc committee, regardless of its admissibility in a court of law.
4. To submit a written statement at the close of the hearing.
5. To receive a copy of the written recommendation of the arbitrator, hearing officer or ad hoc committee provided to the Board of Managers, which includes a statement outlining the basis for the recommendation.

The right to a hearing may be forfeited if the Professional/Provider fails, without good cause, to appear. An attorney or other person of the Professional's/Provider's choice may represent the Professional/Provider. The procedure will be as follows:

1. Board of Managers notifies Professional/Provider of the time, place and date of the hearing via certified mail 30 calendar days prior to the hearing. The Professional/ Provider will also be provided with a list of witnesses expected to testify, if applicable.

2. Arbitrator, hearing officer or ad hoc committee conducts hearing and makes final recommendations. Provides recommendations to Board of Managers.

3. Board of Managers notifies Professional/Provider of final status within 90 calendar days of hearing, via certified mail.

Section 29 Actions Not Giving Rise to a Hearing Right

Hearing rights are not applicable in any of the following circumstances:

1. Appointment of any ad hoc investigation committee.

2. Conducting of an investigation into any matter.

3. Denial, restriction or suspension of participation for a period of not longer than 30 calendar days while an investigation is pending.

4. Formulation or presentation of any preliminary report of any ad hoc investigation committee to the Medical Director or the Board of Managers.

5. Making of a request or issuance of a directive to a participating Professional/Provider to appear for an interview or conference before the Committee, an ad hoc investigation committee, the Medical Director, the Board of Managers or any other professional review body in connection with any investigation, prior to a proposed adverse recommendation or action.

6. Denial or refusal to accept an application for initial appointment or recredentialing:

    a. Where the application is incomplete or untimely.

    b. Where the applicant does not meet the minimum objective requirements for participation or continued participation.

7. Issuance of a letter of warning, admonition or reprimand.

8. Corrective counseling.

9. Recommendation that the participating Professional/Provider be directed to obtain retraining, additional training or continued education.

10. Failure to enter into or termination of the Participating Provider Agreement

11. Suspension or revocation of credentials resulting from the Professional's/Provider's suspension or exclusion from Medicare and/or Medicaid.

12. Suspension or revocation of credentials resulting from the Professional/Provider not having a current active unrestricted license to practice in any state.

13. Any other actions deemed to be voluntary withdrawal or relinquishment of credentialing status by the Professional/ Provider.

14. Any recommendation or action not "adversely affecting" any participating Professional/Provider, or which is not based upon professional competency or the professional conduct of the Professional/Provider.

Section 30 Reporting Obligations

The Staff shall report any action of the Committee to deny, term, not renew or restrict a Professional's/Provider's credentials to the appropriate federal and state authority as required by law. HPS will follow the recommendations made by the NPDB and HIPDB guidebooks on reportable events. (CR9)

Reasons for reporting include, but are not limited to:

1. Abandonment of practice.

2. Breach of confidentiality.

3. Questionable clinical competence.

Section 31 Impaired Applicants and Professionals

Signature Care will not grant approval and will revoke existing status if there is evidence of impaired judgment or performance that could adversely affect patient care due to chemical dependency, physical or mental health conditions (when such conditions and/or problems are noted or suspected). Each case will be investigated and reported to the Committee through the following procedure:

1. Initial applicants and participating Professionals

    a. Chair or Medical Director will issue a letter, via certified mail, within 30 calendar days of noting or suspecting impairment, to the applicant to determine the nature of the condition and the identification of ongoing treatment for the condition.

    b. Chair or Medical Director will issue a letter, via certified mail, within 30 calendar days of receiving information from the applicant, to the treating Professional/Provider to determine if the treatment program is being followed. In addition, they may request periodic documentation of treatment compliance and

notification if the Professional can safely perform duties without impairment of judgment or performance.

c. Documentation, application, and/or participation status will be reviewed by the Committee at its next meeting.

d. Notification of the Committee's action will be issued to the applicant within 30 calendar days via certified mail, with information on the appeal process, if applicable.

Section 32 Ongoing Monitoring

Signature Care reviews all information regarding a participating practitioner obtained through ongoing monitoring to determine if there is evidence of poor quality that could affect the health and safety of its members. As appropriate, interventions are implemented when instances of poor quality or safety issues are confirmed. Any sanctions or limitations on licensure are discussed with the Credentials Committee to determine necessary actions. Problems, concerns and complaints will also be reviewed between recredentialing cycles. Information will be reviewed within 30 (thirty) calendar days, or as reports become available. (CR8) This will be completed by the Staff using any of the following sources:

1. CAQH
2. Office of the Inspector General (OIG) Medicare/Medicaid Sanction (e.g. Office of Inspector (OIG)/HCFA Cumulative Sanctions Report)
3. State Medical Licensing Boards
4. NPDB and HIPDB

If any Professionals/Providers of the network are found to be listed on the report(s), the Medical Director and the Chair will be notified ASAP by the Staff.

The Medical Director and the Chair will assume responsibility for any necessary action which may include:

1. No action necessary
2. Communication with provider about issue in question
3. Recommend further investigation or review.

At the conclusion of any necessary action, this information will be sent to the Staff to be placed in the Professional's/Provider's file and reported to the Committee. (CR8)

When a member files a complaint or there is a concern or problem with a network Professional/Provider (CR8, Factor 3) the following will occur:

1. The Medical Director will investigate each complaint, concern or problem with the Professional/Provider and generate a report. The Medical Director, together with the Chair, will determine whether the complaint should be presented for review by the Committee.

2. A copy of the report will be forwarded to the Staff.

3. These reports will be filed in the appropriate Professional's/Provider's file for review at the time of recredentialing.

4. Staff will monitor practitioner adverse events at least every six months. (An adverse event is an injury that occurs while a member is receiving healthcare services from a Professional.) (CR8)

Exhibit A – Clean Application

1. DEFINITION OF TERMS:

Clean Application - An application that meets the following criteria:

a. Graduation from a recognized school for the appropriate profession (i.e.: medical school, dental school, a podiatry school, chiropractic college, or college as applicable for Allied Health Care Professional certifications.)
b. ECFMG, if applicable.
c. Current active unrestricted state(s) license to practice as appropriate.
d. No current Medicare/Medicaid sanctions.
e. Complete work history - all lapses of 180 days or more explained.
f. Current evidence for professional liability insurance coverage of $250,000/$750,000, showing qualification as a Professional in the Indiana Patient Compensation Fund (IPCF) or professional liability insurance coverage of at least $1,000,000/$3,000,000, or at such higher levels as may be required by law.
g. Have current clinical admitting privileges in good standing at a network facility, as applicable. (See Section 13, i)
h. Acceptable NPDB and HIPDB reports.
i. Have successfully completed residency training appropriate for the time and specialty of practice, or current or previous Board Certification in practicing specialty. Exceptions for family medicine include graduation from medical school prior to 1978, with completion of one (1) year internship, practices as a General Practitioner
j. Have a current CSR and DEA Certification, as required by state, if applicable.
k. Malpractice claims history, included in the application, which contains a detailed report of each liability claim that is open, has been opened pending, settled, arbitrated, mediated, litigated, or has been closed in the previous five years.

i. No more than two malpractice cases closed with payment in the last five (5) years for initial applicants, and no single case with payment greater than $200,.000.
ii. No more than two malpractice cases closed with payment in the past three (3) years for recredentialing applicants, and no single case with payment greater than $200,000.

l. Disclosure of no inability to perform the essential functions of the position, with accommodation.
m. Disclosure of no past or present illegal use of drugs or alcohol and of no treatment for chemical dependency.
n. No history of loss of license, restrictions, or disciplinary actions.
o. For initial credentialing, criminal history with no convictions for any felony and, effective January 1, 2008, no convictions within the preceding six years for misdemeanors related to controlled substances, illegal drugs, insurance or healthcare fraud or abuse, or violence unless the conviction was prior to initial professional licensure. For renewal credentialing, criminal history with no convictions for any felony and no convictions after January 1, 2008 for misdemeanors related to controlled substances, illegal drugs, insurance or healthcare fraud or abuse, or violence unless the misdemeanor conviction occurred prior to initial credentialing. Conviction shall include a plea or verdict of guilty or a conviction following a plea of *nolo contendere*.
p. No disclosure or information from licensure agencies, managed-care networks, insurers, hospitals, facilities or other healthcare practitioners that call into question a Professional's unethical or unprofessional behavior, clinical competency or disruptive behavior which may impede the provision of quality healthcare.
q. No disclosure or information concerning any past denial, non-renewal, or cancellation of malpractice insurance.
r. No disclosure or information concerning any suspension, restriction, loss of privileges or termination by any managed-care plan or hospital.
s. Collaborative Agreement with a participating physician Professional for Nurse Practitioners, Clinical Nurse Specialists, and Certified Nurse Midwives.
t. Supervisory Agreement with all delegated tasks outlined by the supervising physician for Physician Assistants.

A recredentialing application for which the file indicates an issue with respect to any of items h, l, m, n, p, q, and r will nonetheless be considered to be a "Clean Application," but only if: 1) the issue or issues occurred prior to the appointment or recredentialing period which is ending, 2) the issue has been previously reviewed by the Credentials Committee; and 3) no new information about the issue has been disclosed or discovered since the previous review.

II. PROCEDURE:

1. Upon completion of the verification of an application, it is to be reviewed by Staff to see if it meets the definition of a “Clean Application.”

2. If the application meets the definition, the applicant’s name will be entered onto a list to be reviewed by either the Committee Chair or the Medical Director of HPS.

3. The date the Committee Chair or Medical Director initials the application is the credentialing or recredentialing approval date.

Applications deemed other than “Clean Applications” will be reviewed by the Credentials Committee. This will be done at scheduled Committee meetings. This may also be done informally by each individual Committee member’s written consent as long as there is a unanimous decision to approve. Approvals that are not unanimous must then be taken to the next scheduled Committee meeting for review..

GLOSSARY OF TERMS

TERM	DEFINITION
Allied Health Care Professional	An individual Doctor of Chiropractic (DC), Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), Certified Nurse

	Midwife (CNM), Certified Registered Nurse Anesthetist (CRNA), Psychologist (PsyD, PhD, EdD in Clinical Psychology), Licensed Mental Health Counselor (LMHC), Licensed Marriage and Family Therapist (LMFT), Licensed Clinical Social Worker (LCSW), Licensed Clinical Addiction Counselor (LCAC) or Physician's Assistant (PA) currently participating in the Signature Care Network.
Applicant	An individual or Facility that provides health care and wishes to become a Signature Care Professional or Provider.
Clean Application	An application that meets the criteria as established in the Signature Care credentialing policy titled: "PPO Initial and Recredentialing Application Not Needing Credentials Committee Review and Approval" (Exhibit A). With respect to misdemeanors related to controlled substances, illegal drugs, insurance or healthcare fraud or abuse, or violence, a conviction that does not preclude the Professional/Provider from meeting minimum credentialing qualifications shall not cause an application, otherwise meeting the criteria stated above, not to be a Clean Application.
CAQH	Council for Affordable Quality Healthcare
CSR	Controlled Substance Registration
DEA	Drug Enforcement Administration
Professional	An individual Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), Doctor of Podiatric Medicine (DPM.), Doctor of Dental Surgery (DDS) or an Allied Health Care Professional currently participating in the Signature Care Network.
Provider	A facility currently participating in the Signature Care network.
Recredentialing Applicant	A Signature Care Professional/Provider being recredentialed within three (3) years of the previous credentialing.

APPROVAL – SIGNATURE CARE CREDENTIALING PLAN

_____ _____

Ronald L. Baker, MD **Date**
Credentials Chair
Health Plan Services

_____ _____

David T. Sowden, MD **Date**
Chairman, Board of Managers
Health Plan Services

Original Approval:	January 1998
Revised:	April 1999
Revised:	December 1999
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