MOUNTAIN STATE BLUE CROSS BLUE SHIELD
NETWORK CREDENTIALING POLICY & PROCEDURE

TITLE: Professional Network Provider Corrective Action Policy

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Networks and Lines of Business:

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POLICY: The Plan requires that all professional network providers comply with the terms and conditions of their Provider Contracts and meet acceptable standards for quality of clinical care and administrative compliance in order to assure that the network operates in an effective and efficient manner and that members receive high quality and medically appropriate care.

PURPOSE: This policy is intended to outline the procedures of the plan for corrective action and sanctioning of providers arising from non-compliance with contractual obligations or failure to meet acceptable standards of clinical care, and/or administrative compliance. It is also intended to provide a method of ensuring that all physicians/providers who are responsible for delivering medical services to plan members provide a consistent level of high quality, medically appropriate, and ethical medical services. To promote this purpose, the plan establishes this standard policy and procedure for corrective action and sanctioning of professional network providers. It is recognized that provider contracts may provide for termination "without cause" by either the plan or the provider. It is also recognized that provider contracts may be immediately terminated under certain circumstances. It is not the intent or purpose of this Policy to in any manner abrogate or modify any right to terminate network participation "without cause," or immediately, as set forth in any provider contract.

PROCEDURES:

I. **Corrective Action:**

A. Actions Requiring Corrective Action: Certain circumstances, acts or omissions of a professional network provider may, in the Plan's sole discretion, result in a requirement that the provider engage in a corrective action or a series of corrective actions (as described below) in order to continue participation in the network. Treatments, procedures and services that are subject to corrective action include any treatments, procedures or services which indicate a professional provider is practicing in a manner that is not consistent with reasonable standards of care (including, when applicable, accepted standards of medical care) and service, ethical expectations, contractual obligations or the administrative requirements of the plan. Examples of such

circumstances, acts or omissions which may be subject to corrective action include but are not limited to, the following:

1. Clinical Quality of Care

   A quality of clinical care concern arises when any episode of care deviates from accepted medical standards. Such episodes may be identified through a variety of means, for example, member complaints, care management and quality improvement indicators. Any alleged quality of care concern will be investigated with input from the Plan's medical directors and a determination will be made as to whether a deviation from accepted medical standards occurred and the severity of the concern. The occurrence of an adverse outcome does not, in and of itself, indicate a deviation from accepted medical standards and/or warrant any action. Quality of care concerns may include, but are not limited to, the following:

   a. Actions or omissions which result or may result in an adverse effect on a patient's well being;
   b. Delayed services/referrals;
   c. Missed diagnoses;
   d. Medication errors;
   e. Delayed diagnosis/treatment;
   f. Unexpected operative complications;
   g. Invasive procedure complications;
   h. Inappropriate procedures;
   i. Unanticipated, unexplainable death;
   j. Actions requiring a report to the National Practitioner Data Bank or other adverse actions.
   k. Underutilization (i.e., withholding) of necessary and appropriate medical services.

2. Administrative Non-Compliance:

   Administrative non-compliance is defined as behavior that is detrimental to the successful functioning of the plan. When an episode of administrative non-compliance is reported, it will be investigated, and if confirmed, appropriate action will be taken by a medical director. Administrative non-compliance may include, but is not limited to, the following:

   a. Direct or unauthorized billing for services;
   b. Balance billing for services;

c. Failure to cooperate/comply with the plan's administrative, quality improvement, utilization review, member service, reimbursement and/or other procedures;
d. Failure to maintain the Plan credentialing/recredentialing requirements;
e. Failure to cooperate with the Mt. State Quality Management Committee Program;
f. Conduct which is unprofessional toward the member, family members and/or staff of the Plan;
g. Failure to comply with any contractual obligation;
h. Failure to comply with the plan policies and procedures;
i. Failure to comply with or violation of state or federal laws or regulations;
j. Office on-site and/or medical record review deficiencies.

B. Initiation of Corrective Action: Plan employees and/or medical directors who identify or receive information regarding a possible quality of care, administrative non-compliance and/or service related issue shall report this to the Office of Network Credentialing. This is to ensure centralization and tracking/trending of this information for credentialing/recredentialing purposes.

1. The determination to take corrective action shall be made by the Plan's Medical Director and/or the appropriate Credentials Committee.. The practitioner shall be notified in writing by the Medical Director, identifying the issue(s), the type and nature of the corrective action, the severity level of the action, whether a sanctioning applies, the consequences of a sanctioning, the time period during which the corrective action must occur, whether the provider is entitled to a hearing or appeal, and that any request for a hearing or appeal, if applicable, must be made, in writing, within thirty (30) days of receipt of the notification. If a hearing is available pursuant to Section III-A of this policy, the notice must include all of the provisions set forth in Section III-B of this policy. Failure to complete corrective action and/or failure to meet acceptable levels of performance following the completion of the corrective action, in the Plan's sole judgment, may result in termination.

2. The fact that the plan may require certain corrective action under the same or similar circumstances, shall not serve as a waiver of the Plan's right, in its sole discretion, to require a different corrective action at any time from any of its professional network providers. Corrective action may vary according to the situation and may include, but is not limited to, one or more of the following as they relate to the circumstance, action or omission that requires corrective action:

a. Written warning to the provider;

b. Discussion, or series of discussions, with the provider;
c. Monitoring of the provider's performance;
d. Requirement that the provider complete a continuing medical education course regarding the treatment, procedure or service in question;
e. Limitation of the provider's authority to perform certain procedures;
f. Requirement that the provider enter into a preceptor relationship with another provider to monitor and observe the provider subject to corrective action.

Depending on the circumstances, it may be determined that termination is warranted.

3. The determination to take corrective action shall be based on an assessment of the severity level of the action based on the judgment of a medical director. The following are general guidelines for consideration by the Medical Directors for assigning severity levels:

Minor	Deviation from standard of care without harm to member
Moderate	Deviation from standard of care with harm to member that is temporary
Severe	Deviation from standard of care with harm to member resulting in permanent sequelae or death

The categorization of a particular episode of medical care is not dispositive of the level of corrective action that is appropriate. Said determination should be based on all relevant circumstances.

4. In the event a provider desires to seek an appeal of the corrective action, he or she may do so only by submitting in writing to the Medical Director and/or Credentials Committee the basis for disagreeing with the corrective action and supporting documentation. After receipt of this material, the applicable Credentials Committee shall decide whether the corrective action proposed and/or alternative corrective action is warranted. The decisions of the applicable Credentials Committee are final, unless the corrective action decided upon by the applicable Credentials Committee entitles the provider to a hearing under this policy.

II. Sanctioning

A. Sanctioning of a provider will occur whenever:

1. an assessment of the severity level of action is moderate or severe, and/or
2. the corrective action was a result of an Administrative Non-compliance circumstance, act, or omission

B. Sanctioning may result in a provider's practice not being eligible for participation in certain programs, including the Quality Blue Physician Pay for Performance bonus payments.

III. Appeals

A. An appeal shall be made available to a professional network provider before the other regional Credentials Committee (as described in Section III B) if the practitioner is placed under corrective action. The decision of the Committee is final.

B. If an appeal is available pursuant to Section III A, the procedure will be as follows:

1. Notice of Proposed Action

The provider will be given written notice of the proposed action including: (a) the action that has been proposed to be taken against the provider; (b) the reason(s) for the action; (c) that the provider may request an appeal on the proposed action; (d) that the practitioner may participate via phone or in person (e) that the provider will waive any appeal rights if an appeal is not requested within 30 days of receipt of the notice of the action.

2. Notice of Subcommittee meeting

(a) If the provider requests an appeal on a timely basis under Paragraph 1 above, the Office of Network Credentialing will notify the provider of the time and date of the committee meeting.

3. Conduct of Appeal Meeting and Notice

(a) The appeal shall be held before the applicable Credentials Committee which is comprised of network practicing providers, who will review the information presented and render a decision. The members of the Committee shall not be in direct economic competition with the provider.

(b) The provider has the right during the meeting to have representation by an attorney or other person of the provider's choice.

(c) For any appeal the Credentials Committee may consider the report of a specialist regarding the issue at hand.

(d) During the appeal process, the burden of proof is on the provider to establish by clear and convincing evidence that the action being challenged was unreasonable.

(e) After completion of the appeal the provider has the right to receive the written decision of the Credentials Committee from the Medical Director, including a statement of the basis for the decision.

(f) The decision of the Credentials Committee is not subject to further appeal.

IV. Reporting

A. When a final determination has been made concerning a proposed corrective action that adversely affects the clinical privileges or provider status of a provider for a period longer than 30 days, the Director of Network Credentialing or his/her designee shall report such corrective action to the appropriate parties, including the state licensing agency and/or the National Practitioner Data Bank, (NPDB) pursuant to the requirements of the Healthcare Quality Improvement Act and/or the Healthcare Integrity and Protection Data Bank (HIPDB) pursuant to the requirements of the Health Insurance Portability and Protection Act of 1996.

B. Any final determination, which is reportable to the NPDB and/or the HIPDB will be reported to the applicable entity.

C. Nothing set forth in Section III B shall preclude the plan from immediately suspending or restricting clinical privileges where the failure to take any such action may result in imminent danger to the health of any member, provided subsequent notice and right to a hearing are given.

V. Miscellaneous

A. This policy and procedure is not contractual in nature and may, at the plan's sole discretion, be changed.

B. Neither this policy nor the failure to follow such policy, nor any breach related to this policy, is intended to entitle any provider to any additional rights, remedies, damages or injunctive relief.

C. No decisions made hereunder are subject to challenge in any legal or equitable proceeding and may not be presented to arbitration.

D. Nothing in this policy is intended to waive any right that the plan has under any provider contract to immediately terminate the provider contract, or to terminate it after notice, whichever is applicable.

E. The procedure of investigating clinical care complaints used by the Office of Network Credentialing is a component of the Credentialing/ Recredentialing of Network Providers. The process and oversight of such activity is provided by the Credentials Committees. Mt. State considers the activities of the Credentials Committees to be peer protected.