Provider Termination, Appeal Rights and Notification to Authorities

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<td>Approval Signature: Dr. Alexander Blum, CMO</td>
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**Purpose:**

To identify the procedures for suspending or terminating a practitioner’s participation in Evergreen Health’s network, notifying the practitioner of this action and if applicable, offering appeal rights to the practitioner and notifying the appropriate authorities.

Evergreen Health will not suspend or terminate a practitioner solely because the practitioner:

i. Served as an advocate on behalf of a member
ii. Filed a complaint
iii. Appealed an Evergreen Health decision
iv. Provided information to an appropriate agency
v. Requested a hearing or review

**Policy Statement:**

Evergreen Health has the right to suspend or terminate a health care practitioner’s participation in the network based upon the criteria below:

I. Evergreen Health may immediately terminate (administratively) a practitioner’s participation in the network if any of the following occur:
   A. Without Cause:
      1. If there has been a breach of contract by the practitioner or failure to comply with contract requirement.
      2. If a practitioner is suspended or terminated due to a Medicaid/Medicare sanction(s), the practitioner will not be eligible for participation in the Evergreen Health network until the practitioner is eligible for participation in the Medicaid/Medicare program or the sanction(s) has been lifted.
   B. With Cause:
      1. There has been a determination of fraud against the practitioner;
2. The practitioner fails to maintain an active non-restrictive license to practice, certifications, or accreditations required by the practitioner’s agreement with Evergreen Health;
3. The practitioner receives any criminal charges deemed inappropriate by the CMO.

II. Evergreen Health may choose to suspend or terminate a practitioner’s participation in the network for the following reasons:
   A. Quality:
      1. Breach of Performance Improvement requirements
      2. Excessive number of reported adverse events or complaints
      3. Issues relating to or non-compliance with the Evergreen Health Quality Management/Utilization Management Program and Performance Standards (e.g., repeated failures to obtain a passing Medical Record Review score, Quality of Care Issues, under-over utilization, HEDIS results)
      4. If the Evergreen Health decision to suspend or terminate a practitioner’s participation is due to a quality issue, Evergreen Health allows the practitioner to appeal that action. If the practitioner chooses not to appeal, or if the action is upheld following appeal, Evergreen Health reports the action to the appropriate authorities, including state licensing agencies and the NPDB.

   B. Credentialing:
      1. Breach of Credentialing and Recredentialing Policy requirements
      2. If a practitioner has been suspended or terminated for failure to maintain state required licensure, certification, or accreditation, the practitioner will not be eligible for participation in the Evergreen Health network until the practitioner has obtained an active license, certification or accreditation and all internal investigations have been completed. PACC approval must be obtained before the practitioner can be reinstated.
      3. If a practitioner has been terminated because of non-compliance with the recredentialing process, the practitioner must apply for initial credentialing to once again be eligible for participation in the Evergreen Health network.

   C. Behavioral / Citizenship:
      1. Breach of Practitioner Code of Conduct requirements
      2. In the event that the health, safety and welfare of its members may be in jeopardy, Evergreen Health reserves the right to take immediate corrective action with any practitioner, up to and including termination of network participation.

Business Units and Products Affected:

All Products

Definitions:

1. **Adverse determination** – PACC’s decision barring a practitioner from participating in Evergreen Health Practitioner Network

2. **Adverse event** – An injury that occurs while a member is receiving health care services from a provider
3. **Appeal** – A request to change an adverse decision made by the organization. A member or authorized representative of a member may appeal an adverse decision.

4. **Complaint** - An oral or written expression of dissatisfaction by a member

5. **Credentialing Authority** – Generally means the National Committee for Quality Assurance (“NCQA”). Other accrediting body as applicable to Evergreen Health: 1) the Centers for Medicare and Medicaid Services (“CMS”); and 2) as applicable, other applicable state and federal regulatory authorities to the extent such authorities dictate credentialing requirements.

6. **Facility** – An organizational or facility based provider including but not limited to hospitals, Ambulatory Surgery Centers, Skilled Nursing Facilities.

7. **National Committee for Quality Assurance (“NCQA”)** - the organization that develops and publishes quality standards and performance measures for health care entities and whose standards and measures EHC uses to identify opportunities to improve health care quality. Also see Credentialing Authority.

8. **National Practitioner Data Bank (“NPDB”)** - A federally mandated agency that is the repository of information about settled malpractice suits and adverse actions, sanctions or restrictions against the practice privileges of a practitioner

9. **Participating Network Practitioner** - A practitioner, facility, other health care practitioner or provider that satisfies participation criteria established by Evergreen Health, has completed the credentialing process, has been approved to participate in the Evergreen Health Practitioner Network, and has entered a contractual arrangement with Evergreen Health to provide covered services to members

10. **Precautionary Suspension** - A preliminary suspension imposed on a practitioner when his/her actions raise concerns for patients’ safety

11. **Peer Review** - Evaluation or review of colleague performance by professionals with similar types and degrees of expertise (e.g., the evaluation of a practitioner’s credentials and practice by another practitioner)

12. **Practitioner** – Licensed Professionals who provide health care.

13. **Provider** – An institution or organization that provides services, such as, but is not limited to, hospitals and ancillary providers such as home health agencies, skilled nursing facilities, behavioral health centers providing mental health and substance abuse services (inpatient, residential and ambulatory), Federally Quality Health Centers, Rural Health Centers, free-standing surgical centers, and multispecialty outpatient surgical centers or as otherwise defined by Credentialing Authority Procedure(s).

14. **Provider Advisory & Credentialing Committee (PACC)** - The Evergreen Health committee responsible for evaluating the quality, continuity, accessibility and cost effectiveness of clinical care
rendered, as well as the credentialing/recredentialing of Evergreen Health providers and other peer review activities. The PACC includes representation from a range of participating providers in the Evergreen Health network.

15. **Quality Improvement Committee (“QIC”)** - The QIC is the decision making body that is ultimately responsible for the implementation, coordination, integration and oversight of all quality improvement activities and monitoring of all utilization activities for the health plan.

16. **Sanction** – Refers to a finding by a state licensing board, the Office of Inspector General, CMS or other sanctioning body or entity which may affect a practitioner’s ability to practice.

17. **Summary Suspension** - A suspension or restriction of an Evergreen Health’s participating practitioner’s appointment to the Evergreen Health Practitioner Network, where the failure to take such an action may result in an imminent danger to the health of any individual.

18. **Suspension** – Loss of privilege to see Evergreen Health members for a defined time period or limitation of practitioner’s panel.

**Procedure(s):**

Unless immediate action by the Chief Medical Officer (CMO) is warranted, as described in item “1.B” of the Policy Statement above, practitioners who are being considered for suspension or termination will be presented to the Practitioner Advisory & Credentialing Committee (PACC).

**I. Investigation Process**

The Evergreen Health PACC has developed the following process for inquiry into, and investigation of, any allegation against or concerns regarding a participating Practitioner. This includes, but is not limited to, inquiry into and investigation of complaints and identified adverse event reports involving a participating Practitioner. At the sole discretion of the CMO or the PACC, a preliminary inquiry may be undertaken into any matter to assess whether an investigation should be requested or commenced. A preliminary inquiry is not required prior to a request for or commencement of an investigation. At the sole discretion of the CMO or the PACC, an individual(s) will be appointed to investigate allegations against or concerns regarding a participating Practitioner.

Investigation request are submitted in writing to, or initiated by, the CMO or the PACC. The investigation request serves as notification to the practitioner and provides the rational for the investigation. The investigation request maybe initiated based upon reasons outlined in Section B I-III.

The investigation shall be concluded within sixty (60) calendar days of the date of the initial request for investigation, or initiation of the investigation by the CMO or the PACC, unless the CMO or the PACC determines to defer a determination for up to an additional sixty (60) calendar days. Upon completion of the investigation, the individual(s) will submit, within two (2) business days, a written report of their findings to the CMO and the PACC.

A determination will be made and, if found warranted, sanctions will be imposed; and notice of the results of the investigation and any determination will be made to the participating Practitioner under investigation and will include a description of applicable appeal rights.
If new material documentation is received by the CMO, at the discretion of the CMO or the PACC, an investigation may be reopened after a PACC determination has been made.

The CMO or the PACC, may determine, at their sole discretion, not to further pursue the investigation and will submit a report to the QIC with a copy to the participating Practitioner detailing the basis for the determination not to pursue an investigation.

II. Range of Disciplinary Actions

Based upon the findings of the investigation, the CMO or the PACC have the authority to invoke a range of disciplinary actions; corrective action plan, restriction, reduction, alteration, suspension, or termination. See Policy CS-QI-006014 Performance Improvement Process.

A. Corrective Action Plan

   A. If the CMO or the PACC find that a participating Practitioner is performing at a level significantly below target, a corrective action plan (CAP) specific to the deficiencies will be developed, taking into account the Practitioner’s practice characteristics and patient population. The CAP may include the assignment of a peer mentor, as an agent of the Committee, to provide assistance with Plan implementation. This CAP shall be designated as a protected peer review and/or quality improvement document.

   B. Appropriate time frames for regular reports on progress back to the PACC as well as goals for the Provider’s progress will be specified in the CAP. The Practitioner will have sixty (60) days to begin implementation of the CAP (or shorter or longer period of time as is agreed to by the parties based upon the circumstances) and must record this implementation on documents approved by the PACC.

   C. The CMO will continue to work collaboratively with the Practitioner until the performance improvement opportunity has been addressed and corrected. Updates must be provided to the PACC at no less than one hundred eighty (180) day intervals (or such shorter time frame as established by the CAP) until the PACC determines that adequate progress has been made, and the Plan may be considered successfully completed. The CMO will communicate with the Practitioner in writing of the successful completion of the corrective action plan and no further actions are required.

   D. The PACC, following discussion with the CMO, has the authority to terminate a CAP and recommend Adverse Action or Summary Suspension whenever the PACC determines in its sole discretion that sufficient improvement is not being made by the Practitioner justifying the continuance of the CAP. In addition, the PACC may direct the CMO, the Committee’s agent, to immediately initiate a Summary Suspension of a Practitioner whenever the Committee determines, in its judgment, that such action is necessary to protect Evergreen Health patients from imminent danger to their health, welfare, or safety.

B. Precautionary Suspension

The CMO or the PACC have the authority to make a precautionary suspension of a participating Practitioner appointment to the Practitioner Network while the CMO or the PACC conducts an investigation.
Such suspension shall become effective immediately upon notification from the CMO to the participating Practitioner, provided however, that any verbal notifications shall be confirmed in writing, no later than the next business day.

A precautionary suspension shall be deemed an interim precautionary action; it is not a professional review action as reportable to the NPDB and may or may not result in a summary suspension or other sanction dependent upon the findings of the investigation and the determination of the PACC. The Credentialing Manager will immediately report the precautionary summary suspension to the Compliance Officer.

The PACC shall then request an investigation of the matter and shall thereafter present its determination(s) to the participating Practitioner in writing, including the specific reasons for the precautionary summary suspension and a copy of Evergreen Health’s Practitioner Appeals Process as outlined herein, within thirty (30) calendar days of the precautionary summary suspension.

C. Suspension

The CMO or the PACC shall have, without derogation of any other disciplinary authority under Section A of the Policy Statement above, the authority to suspend a participating Practitioner’s Evergreen Health Practitioner Network appointment when:

1. There is an adverse determination by the PACC;
2. An authoritative body, regulatory agency, or governmental agency imposes an action which limits the Practitioner’s ability to meet the requirements of Evergreen Health’s Credentialing Plan; or
3. For any other non-compliance with Evergreen Health’s Credentialing Plan or Evergreen Health’s Policies or Procedures.

A Summary suspension shall be immediately reported to the Compliance Officer and are effective immediately upon being communicated to the participating Practitioner (unless some later date is specified by the PACC) and, if given verbally, will be confirmed in writing no later than the next business day, including the specific reasons for the action and a copy of Evergreen Health’s Practitioner Appeals Process as outlined herein, by the CMO.

A summary suspension is a professional review action as reportable to the NPDB if it is based upon the Participating Practitioner’s competence or conduct (which conducts adversely affects or could adversely affect the health or welfare of a Member(s) and is in effect for more than thirty (30) days. The QIC retains final authority to overturn, modify, or uphold the terms of a Summary Suspension as made by the CMO or PACC.

If the PACC determines that a practitioner’s participation in the network should be suspended or terminated, a written statement explaining the basis for the decision will be placed in the practitioner’s file and documented in the committee minutes.

If Evergreen Health’s PACC determines to suspend or terminate a practitioner’s participation based upon a quality of care issue, the Quality Improvement department will be responsible for initiating and implementing the de-credentialing process.

Evergreen Health’s Practitioner Relations department will review network of practitioners to assure adequacy of coverage of services to member impacted by the suspension or termination. Practitioner
Network will be responsible for required system changes as well as member notification and communications.

III. **Appeals Process**

Upon notification from Evergreen Health of a professional review action for a quality reason, the participating Practitioner will have the right to appeal such professional review action, as outlined below:

In the event that a participating Practitioner’s Evergreen Health Participation Agreement to participate in the Evergreen Health Practitioner Network is not renewed or is suspended or terminated for cause on grounds related to a Practitioner’s qualifications, credentials, professional conduct or competence.

No appeal will be afforded to applicants who fail to meet the minimum basic requirements for network participation as outlined in the CS-CR-001-13 Credentialing and Recredentialing Policy.

A. The Evergreen Health Credentialing Manager provides written notification to the practitioner, via a certified letter signed by the CMO, when the PACC intends to bring a professional review action against the practitioner. The letter includes the reasons for the action and a summary of the practitioner’s appeal rights and process.

B. The practitioner is permitted to request an appeal hearing and is notified of the specific time period for submitting the request. The practitioner is allowed at least 30 calendar days after the notification to request a hearing. If the practitioner has not requested a hearing within the timeframe specified in the letter, the practitioner is deemed to have waived his/her appeal rights.

C. The practitioner has the opportunity during the hearing to present his/her case.

D. The practitioner may be represented at the appeal hearing by an attorney or another person of his/her choice.

E. Within thirty (30) days of being notified of a practitioner’s intent to use the appeal process, the CMO appoints a panel of individuals to review the appeal. The hearing panel consists of at least three (3) non PACC individuals. Of those three (3) individuals, at least two (2) are in network providers who are clinical peers of the practitioner and who are not in direct economic competition with the practitioner. The panel members have the appropriate expertise, qualifications, and experience to address the issues identified in the appeal. The CMO names one of the panel members as the Chair of the hearing panel.

F. The practitioner is notified of the date and time of the hearing, along with the names of the members of the hearing panel and is given the opportunity to object to any panel member.

G. During the hearing the practitioner is given the opportunity to state his/her position and has the right to present written material or other evidence relevant to the matter at issue, as well as to submit a written summary of his/her position.

H. The appealing practitioner bears the burden of proof to show that the intended adverse action was arbitrary, unreasonable, or capricious by a preponderance of the evidence.

I. Following the hearing, the panel deliberates to formulate a recommendation regarding the intended adverse action, which may be to uphold, alter or reverse the proposed action. Recommendation(s) are presented to the PACC.
J. Following review of the recommendation from the hearing panel, the PACC holds the authority for the final decision regarding the proposed action. The PACC shall in good faith attempt to reach a recommendation within (30) thirty days of receipt of the recommendation.

K. If the practitioner does not request an appeal or if the final decision upholds the action to deny, restrict, reduce, alter or terminate the practitioner’s affiliation with Evergreen Health, the Credentialing Manager will notify the practitioner in writing of the decision within ten (10) days of the decision, the notification to include the specific reason for the decision.

IV. Reporting to the National Practitioner Databank and Appropriate Authorities

A. Obligation to Report

Evergreen Health will report any adverse action taken for a quality reason by the PACC against a Practitioner Applicant or a Participating Practitioner to the Evergreen Health QIC with the requirements of the applicable Maryland State Licensing Board. It is the responsibility of the QIC in conjunction with legal counsel to determine if a reportable action has occurred. When required, the Evergreen Health Credentialing Manager will be notified to complete and submit an adverse action report within fifteen (15) calendar days of the adverse action to the NPDB and/or the applicable State Licensing Board, as applicable, and in accordance with the guidelines of the NPDB and/or the State Licensing Board.

V. NPDB Reportable Information

NPDB reportable information may include the following:

A. Any professional review actions, based on a Practitioner’s professional competence or conduct that adversely affects the Practitioner’s clinical privileges for more than thirty (30) calendar days. Reportable adverse actions include reducing, restricting, suspending, revoking or denying privileges, and also include an entity’s determination not to renew a Practitioner’s privileges, if that determination was based on the Practitioner’s competence or conduct.

B. The acceptance of a Practitioner’s voluntary surrender or restriction of clinical privileges while the Practitioner is under investigation for possible professional incompetence or improper professional conduct, or in return for not conducting an investigation or professional review action.

C. Revisions to previously reported actions, such as the reinstatement of the Practitioner’s privileges.

D. Additionally, if errors or omissions are found after information has been reported, an addition or correction to the NPDB must be filed.

E. Evergreen Health may, but is not required to, report such actions taken against the clinical privileges of non-physician health care practitioners.

The information in the NPDB is considered confidential. Disclosure of NPDB information is limited to healthcare entities specified in applicable law and regulations and Participating Practitioners who request information about themselves. The NPDB regulations do not allow disclosure to the general public. Anyone who receives information from the NPDB, either directly or indirectly, is subject to the confidentiality provisions of Title IV of P.L. 99-660, 5 U.S.C 552a, and/or §1128E of the Social Security Act, and the imposition of civil monetary penalty if they violate those provisions.
Related Documents:

The DataBanks, NPDB Guidebook, National Practitioner Databank

Related Policies:

CS-CR-005-14 On-going Monitoring Policy
CS-CR-001-13 Credentialing and Recredentialing Policy
CS-QI-004-13 Peer Review
CS-QI-005-14 Practitioner Code of Conduct
CS-QI-006-14 Performance Improvement

Distribution:

Clinical Services, Practitioner Network Management, Compliance

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