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Quality Management Program Overview

The Independence Quality Management (QM) Program is organized around a vision of supporting optimal health outcomes and satisfaction with care for our Members, as well as meeting all applicable regulatory and accreditation requirements. A philosophy of promoting the Academy of Medicine domains of quality (i.e., Safe, Timely, Effective, Efficient, Equitable, and Patient-Centered care) for our Members informs all QM activities.

The goals of the Independence QM Program include:

- Assess and improve the **safety** of medical and behavioral health care and services our Members receive.
- Evaluate the sufficiency of the plan networks for Members to be able to access qualified Providers for

  timely and appropriate care.
- Ensure evidence-based, **effective** care and services are provided to Members for their medical and behavioral health conditions.
- Promote **efficient** care and reduce health care waste through facilitating communication, continuity, and coordination of care among Providers and supporting a focus on prevention and appropriate level of service.
- Promote health **equity** among diverse populations by identifying and addressing social needs, including access to care that fits cultural and linguistic preferences, and supporting Plan staff cultural humility and awareness of disparities.
- Assess and address the satisfaction of Members with their health care plan and services to support **patient-centered** system improvements.

Our relationships with our network Providers are essential in achieving our quality goals. Since our Providers deliver care to our Members, our role is to assist their efforts and to provide the tools and information needed to maintain the highest standards of care. Likewise, participating network practitioners have a role in supporting the QM Program. They contribute to the planning, design, implementation, and review of the QM Program, policies, and goals through the Clinical Quality Committee and other quality committees, which include network Providers as voting members.

For more information about our QM Program, including our goals and activities, please visit *www.ibx.com* or call Customer Service at 1-800-ASK-BLUE. Members should call the Customer Service telephone number listed on their ID card if they have a concern or complaint about the quality of care or service that they have received.

Provider obligation to cooperate with the QM program

All Participating Providers are required to allow the Plan to use performance data for developing and implementing clinical and service quality improvement activities, public reporting to consumers, preferred status designation in the network, and cost sharing arrangements. All Providers are expected to cooperate with the QM Program, including requests for information and actions to support Member safety activities, complaint and occurrence inquiries, coordination of care, adherence to standards of care, non-discrimination, and other efforts to promote the health and well-being of our Members. Independence requires access to Member medical records at times for a variety of purposes. Providers are responsible for providing Member medical records for any Member they treat, upon request, and coordinating with any file management vendors. In general, medical records must be provided at no charge to Independence. Please refer to your Provider agreement for specific terms and exceptions.

Quality Management activities

The QM Program is an ongoing, comprehensive program that supports continuous quality improvement throughout the organization. We monitor, evaluate, and act to improve the quality and safety of clinical care and the quality of service provided to Members by participating practitioners and Providers, as well as Plan delegates, across all our product lines. We identify opportunities and establish initiatives to improve meaningful clinical outcomes and service quality by monitoring and analyzing:

- claims, pharmacy, and other data to identify high-volume, high-risk, and problem-prone services and acute and chronic conditions;
- data from internal performance monitoring activities and satisfaction survey results;
- data from complaints and appeals and direct input from Members, practitioners/Providers, and Independence staff;
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and Qualified Health Plan Enrollee Experience Survey (QHP EES) Member survey data relating to primary and specialty care;
- Healthcare Effectiveness Data and Information Set (HEDIS®) data for management of certain conditions and medications.

Member safety activities

Nothing is more important than the safety of our Members when receiving clinical care. The QM Program investigates all quality of care complaints and occurrences for quality issues. There are a variety of ways the QM program is alerted to potentially suboptimal care or medical errors that could impact safety for our Members: Member and Provider complaints and grievances, patient safety claim codes and never event reports, care management and coordination team reviews, records audits, appeals, and other sources. Through ongoing education and sharing of effective safety practices, close monitoring of quality data, and collaboration among health care Providers, hospitals, consumers, purchasers, and other stakeholders the QM Program is able to enhance and promote safety for our Members. Our Member safety activities include:

- monitoring and assessing reported safety concerns related to health care delivery to our Members;
- close monitoring of quality, claim, and safety data sources to identify and respond to trends;
- alerting Providers to potential safety concerns and gaps in care for individual Members in their care;
- monitoring the coordination of care of our Members, including between medical and specialty care and medical and behavioral health care;
- identifying processes and practices that have potential to contribute to the reduction of medical and medication errors within our network;
- developing and disseminating information to Providers to promote safe clinical and prescribing practices and optimal outcomes;
- educating Members about patient safety and their role in reducing medical and medication error;
- evaluating the impact of Member safety interventions on our Members' health outcomes;

- recognizing and highlighting facilities that meet quality standards and demonstrate superior outcomes through our Blue Distinction Center® and Blue Distinction Center Plus® Specialty Care Designations;
- close collaboration with health care Providers, hospitals, consumers, and other stakeholders through the Partnership for Patient Care and other collaborations.

Safety occurrence investigations

The QM department investigates all safety occurrences, ensuring appropriate clinical review and follow-up, as well as forwarding documentation of any quality related actions to the Credentialing team for inclusion in the Provider's Plan record. Member safety occurrences are defined as clinical quality or adverse events that occur during inpatient or outpatient treatment that may present a Member safety concern. Occurrences may be related to falls, injuries, hospital readmissions, adverse outcomes related to procedures, inappropriate treatment, etc. Occurrences may be identified by Plan staff, "never event" claims codes, Members, physicians, or Providers.

On receipt of an occurrence, Clinical QM Specialists assess and document the nature of the occurrence, categorize it, and initiate an investigation involving review by a Medical Director. Occurrence investigations include correspondence with the Provider and/or facility involved and may include requests for medical records. Requested records must be provided within 30 days. ***Failure to respond to inquiries regarding occurrences will result in an escalation of the assigned severity of the occurrence.*** Providers with occurrences assigned escalated severity levels may be subject to further peer review and corrective action, as appropriate. Providers are notified of any review of potential quality issues and the determination of any investigation in writing. If the Medical Director determines that there was an actual significant adverse effect on the Member, a corrective action plan addressing the quality issue identified will be requested.

Occurrences are monitored, trended, and analyzed to facilitate the identification of individual outliers and plan-wide trends throughout the year. Outliers with multiple occurrences may be subject to further peer review and corrective action, as appropriate. Plan-wide improvement initiatives may also be implemented in response to identified adverse plan-wide trends, as necessary.

Member complaint process

The QM department investigates all quality of care and service concerns/complaints, ensuring appropriate review and follow-up, as well as forwarding documentation of any quality related actions to the Credentialing team for inclusion in the Provider's Plan record. Members, or their representatives with the Member's consent, may file a concern/complaint by calling Customer Service at the number listed on their ID card or sending their complaint in writing to us by mail or email. Quality complaints are expressions of dissatisfaction with, or criticism of, the quality of care or service received from an in-network Provider or the quality of a practitioner's office site. Quality complaints are typically forwarded to the QM department by Member Services or Appeals and may also be directed from other internal departments.

On receipt of a quality of care or service complaint, QM Complaint Coordinators and/or Clinical QM Specialists assess and document the nature of the complaint, categorize it, and initiate an investigation involving review by a Medical Director. Complaint investigations include correspondence with the Provider and/or facility involved and may include requests for medical records. Requested records must be provided within 5 days. ***Failure to respond to inquiries regarding complaints will result in an escalation of the assigned severity of the complaint.*** Providers with complaints assigned escalated severity levels may be subject to further peer review and corrective action, as appropriate. Providers are notified of any review of potential quality or service issues and the determination of any investigation in writing. If the Medical Director determines that there was an actual significant adverse effect on the Member, a corrective action plan addressing the quality or service issue identified will be requested.

Complaints are monitored, trended, and analyzed to facilitate the identification of individual

outliers and plan-wide trends throughout the year. Outliers with multiple complaints may be subject to further peer review and corrective action, as appropriate. Plan- wide improvement initiatives may also be implemented in response to identified adverse plan- wide trends, as necessary.

A Medicare Advantage grievance is any complaint or dispute raised by a Medicare Advantage Member or the Member's representative, other than a dispute involving an organizational determination. Medicare Advantage grievances may include disputes regarding such issues as office waiting times, practitioner behavior, adequacy of facilities, involuntary disenrollment situations, or coverage decisions by Independence to process a Medicare appeal request under the standard 30-day time frame rather than as an expedited appeal. A resolution will be issued no later than 30 days after the grievance is received.

Monitoring of continuity and coordination of care

Effective continuity and coordination of care promotes both Member safety and the efficient use of health care resources. Care transitions refer to Members moving between health care practitioners and across settings as their conditions and care needs change during the course of a chronic or acute illness. This may include transitions between practitioners (e.g., primary care and specialists, behavioral health practitioner and primary care), and movement across settings of care. Care coordination is the facilitation, across transitions and settings of care, of patients getting the care or services they need and Providers getting the necessary information to provide the highest quality care.

The QM Program conducts an annual assessment of care continuity and coordination across the network to identify opportunities to better support care coordination and continuity between Providers and across settings. Selected HEDIS measures and internal data based on claims inform the assessment of efficiency of care transitions between practitioners or healthcare settings. Data is compiled on documentation of communication between PCPs and specialists, including behavioral health specialists via sample medical chart reviews. Analysis of quality complaints, occurrences, and Member feedback data also helps to identify opportunities to address care continuity. This assessment helps the Plan to set goals for improving care, on which the QM Program evaluates progress annually.

On an annual basis, we collect and analyze data about opportunities for collaboration between medical care and behavioral health care, in the following areas:

- exchange of information
- appropriate diagnosis, treatment, and Referral of behavioral health disorders commonly seen in primary care;
- appropriate use of psychotropic medications;
- primary or secondary preventive behavioral healthcare program implementation;
- management of treatment access and follow-up for Members with co-existing medical and behavioral disorders;
- special needs of Members with severe and persistent mental illness.

QM also works with the Case Management and Utilization Management departments to monitor the coordination of care when Members move from one setting to another, such as when they are discharged from a hospital. The Transition of Care program provides telephonic support to eligible Members and their caregivers as they transition from inpatient care to home. Members are made aware of how they become eligible to participate, how to use program services, and how to opt in or out of the program. Health Coaches provide education and coordinate care services so Members/caregivers learn self-management skills that will ensure their needs are met during the transition and avoid unplanned readmissions or other transitions in care. The program uses an evidence-based model that focuses on four conceptual areas: medication self-

management, understanding and use of the personal health record, primary care and/or specialist follow-up and Member/caregiver knowledge on identification and management of signs and symptoms. Members who require additional support are transitioned into case management or disease management. Without coordination, such transitions often result in poor quality care and risks to patient safety. Analysis of discharge planning and care management data and surveys of practitioners regarding communication and coordination informs the design and implementation of these improvement initiatives.

PCP and Behavioral Health Provider communication

Patients do their best when medical and behavioral health Providers communicate about their care. Dialogue between PCPs and behavioral health Providers can enhance Providers' ability to provide appropriate and patient-centered care, as well as support patient safety, risk identification, and adherence to treatment. Relevant health information to communicate may include medication use (to avoid contraindications), past and present medical conditions, allergies, relevant laboratory results, and contact information for the referring Physician. To facilitate collaboration and coordination in care between PCPs and behavioral health Providers, resources include:

- *Quartet Health Platform*: This secure and virtual platform can be used to screen and refer patients for behavioral health care that matches their clinical needs, personal preferences, and insurance coverage. Members may also be referred to Quartet by an Independence case manager or may sign up for care through the platform on their own. It can be accessed at www.quartethealth.com/.

Physicians must secure and document authorization to release Members' personal health information. Please document each communication with other Providers.

Blue Distinction®

Blue Distinction was created by the Blue Cross and Blue Shield Association (BCBSA), an association of independent Blue Cross® and Blue Shield® Plans, to give consumers more information to make informed health care decisions and to work with Providers to improve health care quality outcomes and affordability.

Blue Distinction® Specialty Care

Our centers of excellence program, Blue Distinction Specialty Care, focuses on hospitals and other health care facilities that excel in delivering safe, effective treatment for specialty procedures. Specialties include: Bariatric (weight-loss) Surgery, Cardiac Care, Cellular Immunotherapy, Gene Therapy, Knee and Hip Replacement, Maternity Care, Spine Surgery, Substance Use Treatment and Recovery, and Transplants. The Blue Distinction Center for Fertility Care designation recognizes practitioners rather than facilities.

Specialty Care recognizes Providers at two levels:

- **Blue Distinction Center.** Demonstrates quality care, treatment expertise, and better overall Member outcomes.
- **Blue Distinction Center+.** Demonstrates more affordable care, in addition to meeting Blue Distinction Center quality criteria.

Blue Distinction Centers for Specialty Care are recognized and are searchable based on the distinction in the online Find a Doctor tool:

- **Commercial Members:** www.ibx.com/Providerfinder
- **Medicare Advantage Members:** www.ibxmedicare.com/Providerfinder

Specialty Care Providers can also be found on the BCBSA's National Doctor and Hospital Finder at www.bcbs.com/find-a-doctor.

The QM Program facilitates applications for Blue Distinction recognition. For more information about Blue Distinction Center Specialty Care, including criteria, visit the BCBSA website at *www.bcbs.com/about-us/capabilities-initiatives/blue-distinction/blue-distinction-specialty-care*.

Total Care

Total Care identifies Physicians, group practices, and hospitals participating in local value-based programs designed to improve health outcomes and lower cost trends through better coordination of care. Total Care-designated Providers receive value-based payments associated with both quality and cost outcomes rather than traditional fee-for-service payments. Independence's Total Care-designated program is the Quality Incentive Payment System (QIPS) program, a Primary Care Provider incentive program. Providers currently participating in the QIPS program are identified as Total Care Providers.

In addition, the Total Care program includes a plus (+) designation, Total Care+, to recognize those Total Care Providers who demonstrate higher quality care at a lower cost than the other Total Care program participants.

Some benefit designs offer Members reduced cost sharing for choosing Total Care and Total Care+ Providers for their care. Members can locate Total Care, and Total Care+ Providers using Independence's Find a Doctor tool at *www.ibx.com/Providerfinder* for Commercial Members or *www.ibxmedicare.com/Providerfinder* for Medicare Advantage Members.

Additionally, Total Care, and Total Care+ Providers can also be found on the BCBSA's National Doctor and Hospital Finder at *www.bcbs.com/find-a-doctor*.

Credentialing and recredentialing policy

Independence is dedicated to recruiting and retaining individual practitioners and institutional Providers with the appropriate credentials to provide Member care and treatment across a range of products and services. Independence does not provisionally credential Providers.

We select qualified applicants in a nondiscriminatory manner, in accordance with our credentialing standards as well as all applicable state, federal, and accreditation requirements. We use several resources to determine the methodology and criteria by which applicants are accepted or rejected for participation or continued participation, such as:

- State/federal law/regulations
- U.S. Department of Health & Human Services (HHS) standards
- Centers for Medicare and Medicaid Services (CMS) standards
- National Committee for Quality Assurance (NCQA) for applicable accrediting requirements

Applicable state and federal requirements will supersede any criteria as defined in this policy. Independence does not discriminate in the administration of these rights based upon the practitioner's race, ethnicity, national identity, religion, age, gender, gender identity, sexual orientation, disability, the types of procedures, or patient type in which the practitioner specializes.

Participation criteria

Please refer to the following participation criteria. Participation criteria apply to practitioners in all settings in which they practice.

- A completed, signed, and dated application includes, but is not limited to:
  - work history for immediate previous five years from the date the application was signed, including month and year, with a written explanation of gaps greater than six months;
  - education and training completed (e.g., medical school, residency training, and fellowships)

  - Providers must have completed all residency/fellowship training for the specialty in which they are applying in order to be considered for credentialing or contracting with Independence. Independence will only accept applications from fellows if they have completed residency training in the specialty for which they are applying.
  - for closed school program verification there is a secure, digital credentialing service designed specifically for physicians through the *Federation of State Medical Boards (FSMB)*. Physicians can request a Lifetime Credential, a secure digitally signed verification of their records from a closed residency program. The Lifetime Credential is considered an official primary source equivalent document by state medical boards. Physicians can contact FSMB at *closedprograms@fsmb.org* or at 1-888-ASK-FCVS;
- statement of chemical dependency or substance abuse;
- loss or limitation of license or felony convictions;
- loss or limitation of hospital privileges or disciplinary action;
- reasons for any inability to perform the essential functions of the position, with or without accommodation;
- an attestation to the correctness and completeness of the application;
- a signed and dated *Authorization for Release of Information* (credentialing warranty).

- Physicians and other health care practitioners including Behavioral Health Providers must have a current, unrestricted license, not subject to probation, proctoring requirements, or other disciplinary action, to practice their specialty in each state in which they are licensed to practice their profession and specialty. The license number must be submitted with the application unless a copy of current license(s) and applicable certifications is required by state or federal law or regulation.
  - Therapeutic optometrists must also have a Therapeutic Pharmaceutical Agent (TPA) license.
  - Chiropractors who perform physical therapy must also have the required adjunctive license as applicable in order to perform those services.
- Board certification:
  - Primary care and specialty care Physicians including podiatrists must be board certified in their area of practice. Exceptions may be allowed for non-board-certified applicants who complete an ACGME\AOA accredited residency or fellowship board certification training program in the same specialty and when Member access issues are identified. A practitioner, whose board provides a clinical pathway for board certification must either obtain the certification directly from the board or obtain written confirmation from the board indicating that the practitioner has met all of the eligibility requirements for the certification of interest. The plans will not assume the role of the board in reviewing a practitioner's qualifications for the purposes of determining eligibility for a clinical pathway for board certification.
  - Physicians and Behavioral Health Providers must be board certified as recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) in their area of practice.
  - Podiatrists must be certified by the American Board of Podiatric Surgery or the American Board of Podiatric Medicine.
  - Psychiatrist & Neurophysiologist as well as Neuropsychologist must be board certified by the American Board of Psychiatry and Neurology (ABPN), or American Osteopathic Board of Neurology and Psychiatry (AOBNP).
    - Lactation Consultants must be certified by the International Board of Certified Lactation Consultants (IBCLC).
    - Board-Certified Behavior Analyst/Behavior Specialist (i.e., Autism) must be a Board-Certified Behavior Analyst (BCBA) through the Behavior Analyst Certification Board

(BACB®)
  - Developmental-Behavioral Pediatrician must hold board certification from the American Board of Pediatrics (ABP) or the American Osteopathic Association (AOA)

- In June 2012, practitioners who were credentialed as General Practice specialists were grandfathered into the specialty “General Practice”. Practitioners are no longer able to be credentialed or recredentialed in the “General Practice” specialty (except those that were previously grandfathered) as this is not a specialty recognized as a board by the ABMS or the AOA.
- Drug Enforcement Agency and Controlled Dangerous Substances certification must be included, when applicable. Certifications are required in each state in which the practitioner provides services for the Plan. Certification number(s) must be submitted with an application, unless copies of the certificate(s) are required by applicable state or federal law/regulations.
- Liability insurance coverage specified by the requirements of the state(s) in which the applicant practices is required.
- Hospital affiliation as required by state law/regulation.
- Practitioner must provide a report detailing malpractice history during the past five years, beginning with the date of the signature on the application. This includes professional liability claims that resulted in settlements, arbitrations, or judgments paid by, or on behalf of, the practitioner.
- Applicants must be currently eligible to receive payment under Medicare/Medicaid and any federal program, including, but not limited to the Federal Employee Health Benefits (FEHB) Program. Medicare opt-out status is reviewed to determine if the applicant has opted out of participating in Medicare programs.

As a condition of participation in Independence’s physical health network, a Physician Assistant (PA) or Certified Registered Nurse Practitioner (CRNP) must have in place a written and signed collaborative agreement with a physician that participates in Independence’s Provider network and has an unrestricted license. The collaborative agreement must comply with all applicable regulatory requirements. A PA or CRNP may provide any medical service as directed by the supervising physician when the service is within the supervising physician’s scope of practice, is included in the collaborative agreement, and is provided with the amount of supervision in keeping with the accepted standards of medical practice.

CRNPs may be independent practitioners (without a physician in the practice) when they have national certification in a certified specialty. As a condition of participation in Independence’s network, a CRNP can practice in a specialist office as long as the specialist is working in the office 75% of the hours to perform the supervision. A CRNP may participate in Independence’s Provider network through a specialist group practice, but the group must include at least one physician that participates in Independence’s Provider network to perform the supervision.

CRNPs and PAs, practicing within a PCP-participating practice or participating specialty Physician group, can be recognized as a Participating Provider. To elect this option, a CRNP or PA must complete the credentialing and contracting process. Once completed, CRNPs or PAs may bill directly, according to their contracted fee schedule, for their services as the performing Provider using their newly assigned Provider number.

Locum tenens

Under certain circumstances, Independence allows for locum tenens arrangements. Locum tenens status is that of an independent contractor rather than an employee. Independence does not credential locum tenens who do not have an independent relationship with the organization. In addition, locum tenens provisions apply only to Physicians. Services of non-Physician practitioners (e.g., Certified Registered Nurse Anesthetists, Nurse Practitioners, and PAs) may not be billed under the locum tenens guidelines from the Centers for Medicare &

Medicaid Services (CMS). These provisions apply only to Physicians.

Locum tenens is a temporary arrangement for when a Provider is absent from their practice for a short period of time due to vacation, illness, family Emergency or other situation. If a Physician is absent longer than 60 days without returning to work, the locum tenens must be credentialed and contracted as a new Physician.

The 60 days is a "consecutive" 60-day period. For example, a locum tenens Physician providing coverage three days a week beginning on September 1 can still only provide services for the same absentee Physician through October 30. This also applies even if several different locum tenens Physicians are used to provide coverage during the 60-day period, because the limitation is tied to the billing of the Q6 modifier, not to the number of days that any particular locum tenens Physician provides coverage.

Therefore, a new 60-day period for billing the services of a locum tenens Physician does not commence as a result of a break in service of the locum tenens Physician. Instead, a new 60-day period commences only by a break in the absence of the Physician for whom a locum tenens Physician is necessary. After the Physician returns to work and provides services for at least one day, then a locum tenens Physician can provide services as a substitute for that Physician again at some point in the future, if necessary, for up to 60 consecutive days.

Credentialing criteria

We require Participating Practitioners to be credentialed and recredentialed at periodic intervals. Thise requirement applies to the following:

- contracted PCPs (defined as family practice, internal medicine, general practitioners, geriatric, and pediatrics),
- specialty Physicians,
- Physician Assistants (PA), Certified Registered Nurse Practitioners (CRNP),
- other allied health practitioners as defined by applicable State or federal law/regulation.

The Plan's contracted Behavioral Health Provider network includes the following categories:

- Individual Behavioral Healthcare Practitioners, such as Psychiatrists and other physicians; Addiction medicine specialists; Doctoral or master's-level psychologists; Master's-level clinical social workers; Master's-level clinical nurse specialists or psychiatric nurse practitioners, and Other behavioral healthcare specialists who may be within the scope of credentialing (e.g., licensed professional counselor).
- Behavioral Health Group Practice, a practice, either contracted through Magellan or independently as a group entity
- Behavioral Health Organizations, a facility or agency licensed and/or authorized by the state in which it operates to provide behavioral health services.

Closed networks

The following professional Provider networks have limitations to participation:

- Pathology
- Podiatry
- Chiropractic

For more information on these closed networks, visit *www.ibx.com/Providers/interactive_tools/credentialing/professional.html*.

Submitting credentialing applications

All professional Providers, including behavioral health practitioners, interested in becoming a Participating Provider must apply for credentialing by:

1. Completing, signing, and submitting a Council for Affordable Quality Healthcare (CAQH) application or other state mandated credentialing application.
   a. The CAQH ProView® is a completely electronic solution that allows Providers to easily submit information through a more intuitive, profile-based design. It is free to Providers and is available on the CAQH website at *proview.caqh.org/pr*.
   b. If your practice contracts with multiple health plans, the CAQH ProView online application minimizes the administrative work needed to fill out multiple, redundant, and time-consuming forms.
   c. To learn more about CAQH, visit *www.caqh.org*.
2. Submitting any supporting documentation necessary, including the *Practitioner Participation Form*. The form can be completed online at *https://fhnportal.ibx.com/ibc/practitionerparticipation/home*.

All information collected during the credentialing/recredentialing process is kept confidential in accordance with applicable State and/or federal law/regulation and our corporate confidentiality policy.

If you have already been credentialed by Independence, there is no need to resubmit a *Practitioner Participation Form* or a CAQH ProView credentialing application.

Contacting Credentialing Operations

Practitioners have the right to be informed of their credentialing or recredentialing application status, upon request. To request the status of their application, practitioners may contact the Credentialing Operations department by email at *credinquiries@ibx.com*. The credentialing staff will respond to the practitioner within two business days of receiving the practitioner's request. The credentialing staff may discuss and provide information to the practitioners, or the designated primary contact for the practitioner, as it applies to their credentialing or recredentialing application, with the exception of references, recommendations, or other peer-protected information.

Credentialing application review

Practitioners have the right to review information submitted in support of their credentialing application with the exception of references or recommendations or other information that is peer-protected. The Credentialing Operations department will notify the practitioner in writing if erroneous information is discovered during the verification process from any primary source. Practitioners have the right to correct any material omission or erroneous information within 10 calendar days of the request and no later than 30 calendar days of the Plan's request for clarification.

Practitioners should submit supporting information or corrections in reference to their *initial credentialing* application in writing to the Credentialing Operations department:

Email: *credinquiries@ibx.com*

Practitioners should submit information or corrections in reference to their recredentialing application in writing to the Credentialing Operations department:

Email: *credinquiries@ibx.com*
Fax: 215-238-2549

Material omissions and/or failure to respond to all questions on the application may result in denial of new or continued participation in our networks.

Practitioners have the right to be informed of their credentialing or recredentialing application status, upon request. To request the status of their application, practitioners may contact the Credentialing Operations department by email at *credinquiries@ibx.com*. The credentialing staff will respond to the practitioner within two business days of receiving the practitioner's request. The credentialing staff may discuss and provide information to the practitioners or designated primary contact for the practitioner as it applies to their credentialing or recredentialing application with the exception of references or recommendations or other information that is peer-protected.

Applicants must have a current unrestricted license, not subject to probation, proctoring requirements, or other disciplinary action, to practice his or her specialty in each state in which the practitioner is licensed. Participating practitioners who no longer meet these licensing requirements will be administratively terminated from further participation in the network, based upon contractual requirements that practitioners must meet. Applicants are notified in writing of determinations regarding approval or denial of participation.

Practitioners are recredentialed every 36 months to ensure that time-limited documentation is updated, that changes in health and legal status are identified, and that practitioners comply with our guidelines and processes and to assess Member satisfaction with the Provider. Failure to complete timely recredentialing may result in administrative termination from the network. We may reinstate a practitioner if all recredentialing requirements are met and the break in credentialing does not exceed 30 calendar days.

Denial appeal and/or review rights

Listed below is important information about the types of denials.

Application denials	No appeal or review rights are available when an applicant fails to submit a timely, completed application.
Administrative denials	Administrative appeal/review rights are set forth in the "Appeal/review process for administrative denials" section. Applicants have a right to appeal to the Credentialing Committee denials of participation that are based on initial credentialing verifications. There are no appeal rights for initial credentialing applicants if it is determined that the applicant's license is restricted, subject to probation, proctoring requirements, or other disciplinary action, or otherwise does not meet the participation requirements as previously noted. The applicant may reapply once the restriction is removed.
Participation denials	A Participating Practitioner who is denied continued participation based on failure to meet recredentialing criteria has appeal rights as set forth in the "Appeal/review process for administrative denials" section. A Participating Practitioner who is denied continued participation based on professional conduct or competence has appeal rights as set forth in the "Provider due process and fair hearing" section. Participation denials or summary suspensions are considered Professional Review Actions in accordance with the Due Process Policy. A Participating Practitioner who is denied continued participation based on a license that is restricted, subject to probation, proctoring requirements, or other disciplinary action has a right to appeal to correct factual inaccuracies regarding the practitioner's licensure status. The Participating Practitioner may reapply once the restriction is removed.

Appeal/review process for administrative denials

A credentialing applicant or a Participating Practitioner is notified by certified mail that he or she has been administratively denied. The letter includes a clear rationale for the decision and instructions on how to submit a written request for an appeal or review, as applicable with additional information, as appropriate, within 30 calendar days of the date of the denial notification letter. Appeal or review requests received after 30 calendar days will not be accepted.

The Credentialing Committee reviews the submitted information and makes a determination of the applicant's participation status at the next scheduled Committee meeting following receipt of the appeal request. The practitioner is notified within seven business days of the final determination via certified mail.

Practitioners who are denied continued participation may reapply after a period of six months. However, under all circumstances, reapplication time frames are solely at our discretion.

Failure to complete timely recredentialing is considered a voluntary withdrawal from our network and is not subject to an appeal. The practitioner may submit the required information to be reinstated or may submit a credentialing application if the break in service exceeds 30 calendar days.

Participating Provider office standards

The QM Program establishes Participating Provider office standards to ensure that its managed care networks are able to effectively meet the needs and preferences of enrolled Members and ensure clinical safety. The cultural needs of Members are taken into consideration, and mechanisms are implemented to provide adequate access to primary, specialty, and behavioral health care practitioners.

Participating Provider office standards relate to the number of office hours practitioners must be available each week, the number of patients seen per hour, maximum wait times for scheduling appointments, patient wait time, no shows, after-hours availability, and health equity considerations.

Independence annually assesses the adequacy of its network in meeting Member needs. Assessments of the type, number, and geographic location of practitioners, Provider office surveys related to appointment availability and after-hours access, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Member satisfaction survey, and quality of care/service concerns serve as mechanisms to monitor performance. We collect and analyze this data to identify opportunities for improvement. Interventions are implemented to improve performance.

Office hours per week

PCP, OB/GYN, high-volume, and high-impact specialists are encouraged to have at least one evening or weekend session/practice per week included in the hours listed.

- PCPs and CRNPs:
  - solo – 20 hours
  - dual – 30 hours
  - group – 35 hours
- Specialty – 12 hours
- Chiropractor – 20 hours
- Podiatry offices – 20 hours

Patients per hour

Maximum patients scheduled per hour per practitioner should not exceed:

- For most practitioners – 4 patients per hour
- For podiatrists and chiropractors – 6 patients per hour

Appointment Availability

Appointments should be readily available for emergent/immediate, urgent, routine appointments, and follow-up visits. Key definitions for types of appointments include the following:

- **Emergency Care:** A medical or psychiatric condition in which symptoms are so severe that the absence of immediate medical attention could place one's health in serious jeopardy. The condition manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
  - Placing the health of the Member or with respect to a pregnant Member, the health of the Member or unborn child, in serious jeopardy;
  - Serious impairment to bodily functions; or
  - Serious dysfunction of any bodily organ or part.
- **Urgent Care:** Necessary treatment for a non-life-threatening, unexpected illness, injury, or condition when the enrollee requires prompt medical attention, is temporarily absent from the service area, or their physician is unavailable. Examples include stitches, fractures, sprains, ear infections, sore throats, rashes and X-rays that are not routine care.
- **Routine Care:** Preventive and/or regular health care that helps people stay healthy and avoid getting sick, including visits with practitioners for medical and/or behavioral healthcare (e.g., mental health, substance use, etc.).
  - **Initial Visit/Physical:** An initial visit and/or a wellness visit.
  - **Follow-up Visit:** A follow-up visit for regular care (e.g., medication, etc.).

Maximum wait times for scheduling appointment types are as follows:

- For primary care and specialty medical practitioners:
  - emergent/immediate – call 911, or go to the nearest emergency room
  - urgent – 24 hours
  - routine primary care
- initial visit – 4 weeks
- follow-up visit – 2 weeks
- follow-up visit after hospitalization or Emergency Department use for behavioral health – 7 business days
  - routine OB/GYN care – 2 months
  - routine specialty care – 2 weeks
- For behavioral health care practitioners:
  - emergent/immediate – call 911, or go to the nearest emergency room
  - non-life-threatening behavioral healthcare emergency – 6 hours
  - urgent – 48 hours
  - routine mental health and substance use disorder care – 10 business days
  - follow-up visit after hospitalization or Emergency Department use for behavioral health – 7 business days

- For practitioners scheduling appointments for CHIP Members:
  - emergent/immediate – call 911, or go to the nearest emergency room
  - urgent – 24 hours
  - routine primary care – 10 business days
  - routine physical – 3 weeks
  - routine visit with Otolaryngologist, Orthopedic Surgery, Dermatology, Pediatric Dentist, Allergist & Immunologist, Pediatric Endocrinologist, Pediatric Gastroenterologist, Pediatric General Surgeon, Pediatric Hematologist, Pediatric Infectious Disease, Pediatric Nephrologist, Pediatric Neurologist, Pediatric Oncologist, Pediatric Pulmonologist, Pediatric Rehab Medicine, Pediatric Rheumatologist, Pediatric Urologist – 15 business days
  - routine visit with other specialists – 10 business days

Patient wait time

Patients should be seen within 30 minutes from the time of the scheduled appointment.

Patient no-show

According to CMS, Medicare Advantage plans, and their contracted Providers, may charge Members administrative fees for missed appointments under certain circumstances. However, if a Provider charges for missed appointments, he or she must charge the same amount for all patients (i.e., Medicare or non-Medicare).

According to the Agreement for Independence-participating Providers, although the Provider may charge for a missed appointment, he or she **may not** charge a "surcharge," such as an added fee – above and beyond their Member liability – for Covered Services. Such a practice creates a barrier to access to care and violates CMS anti-discrimination regulations.

If a patient does not show for a scheduled appointment, it should be documented in his or her medical record.

After-hours availability

Coverage must be provided 24 hours per day, 7 days per week, for our Members.

Covering practitioner must be a Participating Provider. Providers who use answering machines for after-hours service are required to include:

- urgent/emergent instructions as the first point of instruction;
- information on contacting a covering Physician;
- telephone number for after-hours Physician access.

For an urgent/emergent problem, practitioners should respond within 30 minutes.

Health equity

Independence is committed to providing access to culturally and linguistically appropriate (CLAS) health care services in a competent manner. This means all reasonable accommodations are provided to ensure equal access to communication resources for our Members.

Providers are subject to a variety of federal and state laws and regulations regarding the provision of culturally competent and non-discriminatory health care services, including but not limited to Title VI of the Civil Rights Act of 1964, Title III of the Americans with Disabilities Act, and Executive Order 13166 (regarding access to services for persons with limited English proficiency).

Providers are prohibited from discriminating against Independence Members. Discriminatory action,

including violation of the aforementioned regulations or identification of discrimination through quality investigations, may subject a Provider to corrective action and possible termination from the network.

Language assistance services

Independence makes interpretation services available to practitioners. Your Independence patients can call the Customer Service number on the back of their Member ID card to request telephone interpretation for a preferred spoken language or video interpretation for sign language. Free telephone relay services are also available at TTY/TDD: 711.

Your Independence patients can also call the Customer Service number on the back of their Member ID card to request additional language assistance services. Members may request that information about their plan be shared via audio recordings or via printed documents in other languages, large print, or Braille.

Note: According to the U.S. Department of Health and Human Services (HHS) the assistance of friends or family is not considered competent, quality interpretation. These persons should not be used for interpretation services except where a Member has been made aware of their right to receive free interpretation and continues to insist on using a friend or family member for assistance in their preferred language.

Cultural Competence

The National Standards for CLAS in Health and Health Care were developed by HHS. They are intended to advance health equity, improve quality and help eliminate health care disparities by establishing a blueprint for providing effective, equitable, understandable, respectful, and quality health care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Below are several of the CLAS standards which Independence encourages all Providers in our network to adopt in furtherance of providing culturally competent care:

- Provide effective, understandable, and respectful care to all patients in a manner compatible with the patient’s cultural health beliefs and practices of preferred language/format.
- Implement strategies to recruit, retain, and promote a diverse office staff and organizational leadership representative of the demographics in your service area.
- Educate and train staff at all levels, across all disciplines, in the delivery of culturally and linguistically appropriate services.
- Establish written policies to provide translation and interpretive services for patients upon request.
- Routinely document patient preferred language or format, such as Braille, audio, or large type, in all medical records.

Member rights and responsibilities

Member rights

A Member has the *right* to:

- receive information about Independence, its benefits, services included or excluded from coverage, policies and procedures, participating practitioners/Providers, and Member rights and responsibilities. Information provided will be in a manner and format that is easily understood and readily accessible.
- obtain a current directory of Participating Providers in the plan’s network, upon request. The directory includes addresses, telephone numbers, and a listing of Providers who speak

languages other than English.

- prompt notification of terminations or changes in benefits, services, or Provider network;
- be treated with courtesy, consideration, respect, and recognition of their dignity and right to privacy;
- confidential treatment of personally identifiable health/medical information. Members also have the right to access their medical record and ask that it be amended or corrected, in accordance with applicable federal and State laws.
- receive health care services without discrimination based on race, ethnicity, age, mental or physical disability, health status, genetic information, color, religion, gender, sexual orientation, national origin, source of payment, utilization of medical or mental health services or supplies, or the filing by such Member of any complaint, grievance, appeal or legal action against Professional Provider, a Group Practice Provider (if applicable) or Independence;
- participate with practitioners in making decisions about their health care
- formulate and have advance directives implemented.
- candid discussions of appropriate or Medically Necessary treatment options and alternatives for their conditions, regardless of cost or benefit coverage, in terms that the Member understands, including an explanation of their complete medical condition, recommended treatment, risks of treatment, expected results, and reasonable medical alternatives. If the Member is not capable of understanding this information, an explanation shall be provided to his or her next of kin or guardian and documented in the Member's medical record.
- the rights afforded to Members by law or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language the Member understands;
- voice and file complaints (sometimes called grievances) or appeals about Independence or the care it provides and receive a timely response about the disposition of the appeal/complaint and the right to further appeal through an independent organization for a filing fee or the applicable regulatory agency, as appropriate. A doctor cannot be penalized for filing a complaint or appeal on a Member's behalf.
- make recommendations regarding our Member rights and responsibilities policy by contacting Customer Service
- choose practitioners/Providers within the limits of covered benefits, availability, and participation within the Independence network;
- a choice of specialists among Participating Providers following an authorized Referral, as applicable, subject to their availability to accept new patients; for Members with chronic disabilities, the right to obtain assistance and Referrals to Providers with experience in the treatment of their disabilities.
- continue receiving services from a Provider who has been terminated from the Independence network (without cause) in the timeframes defined by the applicable State requirements of the Member's benefit plan. This does not apply if the Provider is terminated for reasons which would endanger the Member, public health or safety, breach of contract, or fraud.
- be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation by contracted Providers of Independence.
- available and accessible services when Medically Necessary, including availability of care 24 hours a day, 7 days a week, for urgent and emergent conditions;
- call 911 in a potentially life-threatening situation without prior approval and have Independence pay per contract for a medical screening evaluation in the emergency room to determine whether an Emergency medical condition exists;
- be free from balance billing by Providers for Medically Necessary services that were

authorized or covered, except as permitted for copayments, coinsurance, and deductibles by contract;

- be free from lifetime or yearly dollar limits on coverage of essential health benefits;
- be free from unreasonable rate increases and to receive an explanation of rate increases of 15% or more before the Member's premium is raised;
- choose an individual On-Exchange health plan rather than the one offered by an employer and to be protected from employer retaliation.

Member responsibilities

A Member has the *responsibility* to:

- communicate, to the extent possible, information Independence and Participating Providers need in order to provide care;
- follow the plans and instructions for care agreed to with their practitioners. This includes consideration of the possible consequences of failure to comply with recommended treatment.
- understand their health problems and participate in developing mutually agreed upon treatment goals, to the degree possible;
- review benefits and Member materials carefully, follow the policies and procedures of the health plan, and advise Independence of any questions or concerns;
- be considerate and act in a way that helps the smooth running of Providers; offices and facilities;
- pay premiums and any cost-sharing owed (deductibles, coinsurance, or copayments, as appropriate) and meet other financial responsibilities described in the Member's contract/Evidence of Coverage;
- pay for charges incurred that are not covered under, or authorized under, the Member's benefit policy or contract;
- for point of service contracts, to pay for charges that exceed what Independence determines as customary and reasonable (usual and customary, or usual, customary and reasonable, as appropriate) for services that are covered under the out-of-network component of the Member's benefit contract.

Additional Medicare Advantage Member rights

A Medicare Advantage Member has additional rights, including the *right* to:

- get information in a way the Member understands from Medicare, health care Providers, and, under certain circumstances, contractors;
- get information in a way the Member understands about Medicare and get answers to questions to help him or her make health care decisions, including what is covered, how doctors are paid, what Medicare pays, and how much they have to pay;
- see Independence Providers and get covered health services and drugs within a reasonable period of time, in a language the Member can understand and in a culturally sensitive way;
- get a decision about health care payment, coverage of items or services, or prescription drug coverage before getting services. If you disagree with the decision of your claim, you have the right to file an appeal.

Additional Medicare Advantage Member responsibilities

A Medicare Advantage Member has additional responsibilities, including the *responsibility* to:

- notify Providers that they are enrolled in our health plan when seeking care (unless it is an Emergency);
- notify the health plan if they have additional health insurance or prescription drug coverage;

- notify the health plan if they move.

Provider responsibilities

Providers contracted with Independence are required to comply with Independence's QM Program and quality improvement activities, including allowing the Plan to use their performance data. Providers have the responsibility to:

- ensure that all necessary authorizations are obtained prior to rendering services;
- maintain a professional physician-patient relationship with each Member for whom you provide a covered service;
- maintain Member confidentiality and comply with HIPAA† regulations;
- respect Member rights and responsibilities;
- comply with QM Program initiatives and any related policies and procedures;
- comply with QM requirements, including, but not limited to:
  - cooperate with the onsite medical review process and provide medical records when requested for clinical and/or service outcome measures;
  - respond to investigations of Member complaints regarding quality of care and services;
  - cooperate with the development of corrective action plans when measurements identify opportunities for improvement or as a result of a quality of care inquiry.

†HIPAA, the Health Insurance Portability and Accountability Act, was enacted by the U.S. Congress in 1996, and became effective July 1, 1997. This act is a grouping of regulations that work to combat waste, fraud, and abuse in health care delivery and health insurance. The intention of HIPAA is also to improve the effectiveness and efficiency of the health care system; portability, privacy and security of protected health information, continuity of health insurance coverage in the group and individual markets; and the ability to provide consequences to those that do not apply with the regulations explicitly stated within the Act.

Medical record keeping standards

A medical record documents a Member's medical treatment, past and current health status, and treatment plans for future health care and is an integral component in the delivery of quality health care. As such, we routinely distribute our established medical records standards.

Medical record content and documentation standards

History and physical. The history and physical examination identifies appropriate subjective and objective information pertinent to the patient's presenting complaints.

The History and physical should contain:

- History of Present Illness.
- Past medical history
  - A Past medical history (for patients seen three or more times) that is easily identified and includes serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.
- Medications and allergies
  - Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
  - Documentation of medications that are current and updated.
  - Documentation of food and other allergies, such as shellfish or latex, that may affect medical management.

- Family or social history
  - For patients 12 years and older, there is appropriate notation concerning the use of cigarettes, alcohol, and substances (for patients seen three or more times, query substance abuse history).
- Prevention screening
  - An immunization record (for children) that is up to date or a suitable history has been made in the medical record (for adults).
  - Preventative, and risk screening.
  - Evidence that preventive screening and these services are offered in accordance with the organization's practice guidelines.
- Review of systems - physical exam
- Data collection - tests
- A problem list
  - Significant illnesses and medical conditions are indicated on the problem list.
  - Unresolved problems from previous office visits are addressed in subsequent visits.
- Diagnoses
  - The documentation of clinical findings and evaluation for each visit is included.
- Treatment plan
  - Working diagnoses are consistent with findings.
  - Treatment plans are consistent with diagnoses.
  - There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
  - Laboratory and other studies are ordered, as appropriate.

Medical record keeping system

Information filed:

1. All services provided directly by a practitioner who provides primary care services.
2. All ancillary services and diagnostic tests ordered by a practitioner.
3. All diagnostic and therapeutic services for which a Member was referred by a practitioner, such as:
   - home health nursing reports
   - specialty physician reports
   - hospital discharge reports
   - physical therapy reports
4. An advance directive that is prominently documented in each adult (18 and older) Member's medical record. Information as to whether the advance directive has been executed also noted.
5. Records of hospital discharge summaries and emergency room/department visits.
6. If a consultation is requested, there is a note from the consultant in the record.
7. Laboratory and other studies ordered.

Standards for availability and retrieval:

1. Medical records must be made available to the Plan as defined in the Professional Provider Agreement.
2. Medical records must be organized and stored in a manner which allows easy retrieval.

Organization:

1. Each page in the record contains the patient's name or ID number.
2. Personal biographical data include the address, employer, home and work telephone numbers and marital status. Consider including race, ethnicity, primary language, sexual orientation, and gender identity.
3. All entries in the medical record contain the author's identification. Author identification may be a handwritten signature, unique electronic identifier, or initials.
4. All entries are dated.
5. There is review for under - or overutilization of consultants.
6. The record is legible to someone other than the writer.
7. Encounter forms or notes that have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or on a schedule deemed necessary.
8. Specialty physician, other consultation, laboratory, and imaging reports filed in the chart are initialed by the practitioner who ordered them to signify review. Review and signature by professionals other than the ordering practitioner do not meet this requirement. If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.

Confidentiality

1. Protected Health Information (PHI) must be protected against unauthorized or inadvertent disclosure.
2. Medical records must be safeguarded against loss or destruction and maintained according to state requirements. At a minimum, medical records must be maintained, beginning on the date of the last medical service, for at least 11 years, or age of majority plus six years, whichever is longer.
3. Medical Records must be stored securely in a way that allows access by authorized personnel only.
4. Staff must receive periodic training on health information confidentiality.

Monitoring and performance goals

The Plan regularly assesses the quality of medical record keeping and compliance with these standards through medical record review; and monitors the processes and procedures used by physician offices to facilitate the delivery of continuous and coordinated medical care. Performance goals have been established to assess the quality of medical record keeping.

The Plan monitors compliance with the medical record standards outlined in this policy through mechanisms that include:

- Assessments completed for improvement of the medical record keeping practices of practitioners who provide care such as: PCPs, OB-GYNs, and high-volume behavioral health specialists.
- Assessments performed as part of the Plan's performance monitoring and improvement activities.

The Plan has established a minimum acceptable overall score of 90% for compliance with standards for medical records and plan-wide compliance rates in studies that assess performance across the practitioner network. Where actual performance falls below established goals, practice-specific or plan-wide improvement activities are initiated as appropriate.

Maintenance of records and audits

Medical and other records

Providers must maintain all medical and other records in accordance with the terms of their Agreement with Keystone Health Plan East and QCC Insurance Company (collectively, “Independence”) and this *Provider Manual for Participating Professional Providers*. Subject to applicable State or federal confidentiality or privacy laws, Independence or its designated representatives, and designated representatives of local, State, and federal regulatory agencies having jurisdiction over Independence, shall have access to Provider records, on request, at Provider’s place of business during normal business hours, to inspect, review, and make copies of such records.

When requested by Independence or its designated representatives, or designated representatives of local, State, or federal regulatory agencies, the Provider shall produce copies of any such records and will permit access to the original medical records for comparison purposes within the requested time frames and, if requested, shall submit to examination under oath regarding the same.

If a Provider fails or refuses to produce copies and/or permit access to the original medical records within 30 days as requested, Independence reserves the right to require Selective Medical Review before claims are processed for payment to verify that claims submissions are eligible for coverage under the benefits plan.

Provider termination with cause

We may terminate the Professional Provider Agreement (Agreement) immediately upon notice to the Provider in accordance with the Agreement for causes including, but not limited to:

- Provider’s violation of any applicable law, rule, or regulation;
- Provider’s failure to meet and maintain our credentialing requirements including, but not limited to, maintaining the professional liability insurance coverage, licensure, and credentialing status;
- Provider action that, in our reasonable judgment, constitutes gross misconduct;
- Provider action that we determine places the health, safety, or welfare of any Member in jeopardy.

We will not sanction, terminate, or fail to renew a Provider’s participation for any of the following reasons:

- discussing the process that we, or any entity contracting with us, use or propose to use to deny payment for a health care service;
- advocating for Medically Necessary and appropriate care with or on behalf of Members, including information regarding the nature of treatment; risks of treatment; alternative treatments; or the availability of alternative therapies, consultations, or tests;
- discussing our decision to deny payment for a health care service;
- filing a grievance on behalf of, and with the written consent of, a Member or helping a Member file a grievance;
- taking another action specifically permitted by Pennsylvania Act 68.

Provider due process and fair hearing

Our Due Process policy governs: (1) hearings on recommended Professional Review Actions (“Professional Review Action”) as defined below involving the Plan’s participating practitioners ("practitioners") and (2) hearings on Emergency Professional Review Actions ("Summary

Suspensions") involving the Plan's participating practitioners, which are based on the professional conduct or competence of the practitioner. All hearings are conducted in accordance with the procedural safeguards set forth in the Due Process policy and provided in this section to ensure that the affected practitioner is accorded all rights to which he/she is entitled.

Definitions

Professional Review Action: Any reduction, restriction, suspension, revocation, or denial of a Practitioner's status as a Participating Practitioner with Independence based on quality and/or professional competence of the Practitioner.

Summary Suspension: Adverse action taken against a Practitioner before a hearing is held. Independence may initiate a Summary Suspension where we determine that failure to suspend or restrict the Practitioner's participation may result in imminent danger to the health, welfare, or safety of an Independence Member.

Practitioner: Currently licensed health care Practitioner in an independent practice who contracts with Independence and who has been credentialed by us.

Procedures

1. **Hearings**

1.1 Procedural Rights

All hearings shall be conducted in accordance with the procedural safeguards set forth in this Policy to ensure that the affected Practitioner is accorded all rights to which he/she is entitled. Notwithstanding any other provision of this Policy, no Practitioner shall be entitled, as of right, to more than one hearing with respect to a Professional Review Action or Summary Suspension taken against that Practitioner.

1.2 Notice to Practitioner, Request for Hearing and Waiver

The Vice President Quality Management or his/her designee shall give prompt written notice of a proposed Professional Review Action or a Summary Suspension to an affected Practitioner. The notice shall provide the reasons for the action and a summary of hearing rights and procedures set forth in Paragraphs 1.2.1, 1.2.2, 1.2.3, 1.3, 1.4, 1.5, 1.6, and 1.7 of this Policy and all subparts thereof. Notice to the Practitioner as set forth herein does not apply when (i) there is no adverse Professional Review Action taken, or (ii) a suspension or restriction of clinical privileges does not exceed fourteen (14) days during which an investigation is conducted to determine the need for a Professional Review Action.

1.2.1 Practitioner's Request for Hearing – Form and Time Limit

Any request for a hearing by a Practitioner must be in writing and delivered (by hand delivery or certified mail, return receipt requested) to the person designated in the notice, within thirty (30) days of the date of the notice.

1.2.2 Waiver of Hearing

The failure of a Practitioner to request a hearing to which he/she is entitled by this Policy within thirty (30) days of the date of the notice of the Professional Review Action or Summary Suspension and in the manner herein provided shall be deemed a waiver of his/her right to such hearing.

1.2.3 Effect of Waiver of Hearing

When a hearing is waived, the Vice President Quality Management or his/her

designee shall decide whether a proposed Professional Review Action shall become effective or a Summary Suspension shall remain in effect against the Practitioner. The decision of the Vice President Quality Management or his/her designee on a Professional Review Action or Summary Suspension shall become final, binding, and unreviewable with the same force and effect as if a hearing had been requested and duly held and a decision rendered by a Hearing Committee. The decision of the Vice President Quality Management or his/her designee shall be communicated in writing to the Practitioner.

1.3 Notice of Hearing

Within thirty (30) days after receipt of a request for a hearing, which complies with the provisions of Paragraph 1.2.1 of these procedures, the Vice President Quality Management or his/her designee shall schedule and arrange for such a hearing and shall notify the Practitioner in writing of the time, place, and date so scheduled.

1.3.1 Date of Hearing

The hearing date shall not be less than thirty (30) days nor more than sixty (60) days from the date of notice of the hearing, unless such timing is specifically waived by the affected Practitioner and alternative dates are mutually agreed upon by the affected Practitioner and the Vice President Quality Management or his/her designee.

1.3.2 Contents of Notice

The notice of hearing shall provide a list of the witnesses, if any, expected to testify on behalf of the Plan.

1.4 Notice Regarding Practitioner’s Witnesses

The Practitioner or his/her representative shall provide to the Chair of the Hearing Committee (as hereinafter defined), in writing, a list of those persons, if any, he/she expects to call as witnesses at the hearing at least ten (10) days prior to the date of the hearing. Failure to identify a witness at least ten (10) days prior to the hearing will result in the exclusion of that witness’s testimony absent compelling circumstances as determined by the Vice President Quality Management or his/her designee physician.

1.5 Composition of Hearing Committee

The hearing shall be conducted by the Regional Peer Review Hearing Committee (“Hearing Committee”). Except as set forth in Section 1.8 below, the Hearing Committee shall be composed of at least three (3) Members inclusive of the Vice President Quality Management or designee Physician, a Plan Medical Director. The majority of the Hearing Committee will be composed of network Physician peers of the affected practitioner, preferably from one of the Plan’s Physician committees. The remainder of the Members of the Hearing Committee may be appointed by the Vice President Quality Management or his/her designee, who shall then designate one of the Members so appointed to be the Chair of the Hearing Committee. Network Physicians are the only voting Members of the Hearing Committee, unless there is a tie in the Hearing Committee’s decision, in which case, the Chair of the Hearing Committee may vote.

1.5.1 Qualifications

No Member of the Hearing Committee shall be in direct economic competition with the practitioner involved. A Hearing Committee Member is not disqualified from serving on a Hearing Committee because he/she has heard of the case and/or has knowledge of the facts involved. The Members of the Hearing Committee shall give fair and impartial consideration to the case.

1.6 Conduct of Hearing

The hearing shall be conducted in accordance with the rules set forth herein. If in the course of the hearing, a matter arises which this Policy does not address, the Chair of the Hearing Committee is authorized to determine the applicable procedure(s).

1.6.1 Committee Presence

Except as set forth in Section 1.8 below, at least three Members of the Hearing Committee shall be present when the hearing takes place.

1.6.2 Practitioner Presence

The personal appearance of the Practitioner for whom the hearing has been scheduled shall be required. Except as set forth in Section 1.8 below, a Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her right to a hearing and the right shall be forfeited.

1.6.3 Rights of Parties

During a hearing, each party may:

(a) call, examine, and cross-examine witnesses on any matter determined by the Chair of the Hearing Committee to be relevant to the issues;

(b) introduce exhibits or otherwise present evidence determined by the Chair of the Hearing Committee to be relevant to the issues;

(c) submit written reports, including but not limited to expert reports or any findings of the Plan committee(s) that investigated the Practitioner in question. Any expert report submitted on behalf of the Plan shall be authored by an independent medical expert who does not serve on the Hearing Committee;

(d) request that a record of the hearing be made by use of a State-certified court reporter. Each party shall bear his/her or its own costs to purchase a transcript; and

(e) submit a written statement to the Hearing Committee at the close of the hearing.

If the Practitioner does not testify on his/her own behalf, he/she may be called and examined by the Hearing Committee.

1.6.4 Witness Fees

Each party shall bear his/her own fees, costs, and expenses including attorney's fees with respect to witnesses testifying or other evidence submitted on his/her behalf.

1.6.5 Procedure and Evidence

The hearing need not be conducted according to the rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which a responsible person might customarily rely in the conduct of serious affairs may be considered regardless of the admissibility of such evidence in a court of law. The Chair of the Hearing Committee shall make all determinations regarding the admissibility of evidence. The Chair of the Hearing Committee shall be required to order that oral evidence be taken on oath or affirmation. Any written statement submitted by a party at the close of a hearing shall become part of the hearing record. The Chair of the Hearing Committee may set time limitations for the presentation of evidence and may exclude or limit evidence

that is repetitive or cumulative.

1.6.6 Burden of Proof

The Practitioner has the burden of proving by a preponderance of the evidence that the proposed Professional Review Action or Summary Suspension lacks any reasonable basis or that the conclusions drawn therefrom are arbitrary and capricious.

1.6.7 Hearing Officer

The Chair of the Hearing Committee shall preside over the hearing to determine the order of procedure during the hearing, to ensure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.

1.6.8 Representation

(a) The Practitioner shall be entitled to be accompanied by and represented at the hearing by a representative or an attorney of his/her choice.

(b) The Hearing Committee and Plan also may have their respective attorneys present in person or telephonically during the hearing. The Practitioner or one or all Members of the Hearing Committee or the Chair of the Hearing Committee or his/her designees may, if they deem it necessary, consult with their attorney during the hearing.

1.6.9 Deliberations, Recesses, and Adjournment

The Hearing Committee may, without prior notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence and submission of any written statements, including receipt of any new or additional evidence or consultation requested by the Hearing Committee, the hearing shall be closed. The Hearing Committee shall, at a time convenient to itself, conduct its deliberations outside the presence of the Practitioner for whom the hearing was convened and any representatives or witnesses of the Practitioner. The Hearing Committee's deliberations may be in person or by conference call.

1.7 Written Report

Within seven (7) business days after final adjournment of the hearing, the Hearing Committee or its designee shall make a written report and recommendation (the "Report") including a statement of the basis for the recommendation and shall forward the same together with the hearing record and all other documentation, to the Vice President Quality Management or his/her designee. The Report shall include the effective date of the recommendation with respect to the proposed Professional Review Action or Summary Suspension. The Practitioner will be notified in writing in the event the Hearing Committee requires additional time to issue the Report.

1.7.1 Action on Hearing Committee Report

Within seven (7) business days after receipt of the Report, the Vice President Quality Management or his/her designee shall send a written decision to the Practitioner and/or to his/her representative at the hearing, if any, by certified mail, return receipt requested. Based on a totality of the information presented at the hearing, including documentary and testamentary evidence, and the written recommendation of the Hearing Committee, the Plan may uphold the initial determination or Summary Suspension, reverse the initial determination,

reinstate the Practitioner, impose terms or conditions for maintaining participation with the Plan, and/or take any other action deemed appropriate.

1.7.2 Effect of the Hearing Committee Report

The determination of the Hearing Committee shall be final, binding, and unreviewable.

1.7.3 Professional Review Action Report

If a Professional Review Action is deemed final, or if a Practitioner voluntarily relinquishes participation in the Plan or if a Practitioner waives a hearing in exchange for the Plan foregoing an investigation and/or peer review committee action, such actions shall be reported to all appropriate agencies, boards, or other entities in accordance with applicable law/regulation.

1.8 Procedural Modifications

In the event of a circumstance that arises that is beyond the Plan's control including, but not limited to a pandemic, flood or tornado, that make performance of the procedural requirements in Section 1.5, **Composition of the Hearing Committee,** Section 1.6.1, **Committee Presence,** or Section1.6.2, **Practitioner Presence** inadvisable, commercially impracticable, illegal, or impossible, the Plan shall provide advance notice to Practitioner and the Hearing Committee of such procedural changes that are warranted under the circumstances.