Arizona Priority Care™

One Goal. One Priority. Your Healthcare.

Credentialing Plan 2024

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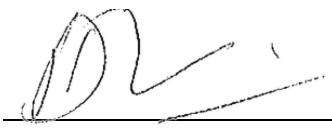
Approval Signature:



4/18/2024

Dr. Pawan Dhawan, Committee Chair *Date*

CHAPTER I PRACTITIONER CREDENTIALING

Chapter I Practitioner Credentialing

1 Purpose

Arizona Priority Care, Inc. (referred to herein as "AZPC") has developed and implemented a comprehensive Credentialing Plan for the purpose of selecting and evaluating licensed independent practitioners or groups of practitioners in a nondiscriminatory manner who provide services within its delivery system. The Credentialing Plan has been formulated to meet the requirements of contracted Health Plans, National Committee for Quality Assurance (NCQA), Arizona Department of Health Services (ADHS), Medicare, and other federal and state regulations.

2 Scope of Authorization and Action

Licensed practitioners who treat members in the inpatient and/or outpatient setting are covered under the Credentialing Plan. This includes:

- employed practitioners,
- independent practitioners or groups of practitioners
- contracted licensed hospitalists

Independent practitioners or groups of practitioners include any allied health practitioner or behavioral health care specialist who is licensed, certified or registered by the State of Arizona to practice independently (may include Physician Assistants or Physical Therapists).

Doctors of Dental Surgery are required to be credentialed only if they provide care under the managed care organization's medical benefits.

Practitioners Not Covered Under Credentialing Plan

A. Practitioners who practice exclusively within the inpatient hospital setting and have no independent relationship with AZPC are not subject to the Credentialing Plan, specifically:
    - Radiologists,
    - Anesthesiologists,
    - Emergency room physicians,
    - Pathologists,
    - Behavioral healthcare practitioners,
    - Hospitalists,
    - Telemedicine consultants,
    - Locum Tenens

B. Practitioners who practice in freestanding facilities, such as mammography centers, urgent care centers, surgical centers and ambulatory behavioral health care facilities are not subject to the Credentialing Plan.

However, if these practitioners provide care in addition to the care provided in the inpatient setting or emergency room, they are subject to the Credentialing Plan.

2.1 Physician Extenders

Licensed independent practitioners who fall within the scope of Physician Extenders include Physician Assistants (PA) and Nurse Practitioners (NP). Physician Extenders are required to properly identify themselves to patients as non-physician practitioners.

State licensing authorities have developed specific guidelines and standardized procedures for Physician Assistants. A Supervising Physician is designated to provide physician collaboration/supervision of the Physician Assistant that is consistent with the Physician Assistant's scope of practice. Supervising Physicians have continuing responsibility for all medical services provided by the Physician Assistant under his/her supervision.

The Physician-to-Physician Assistant ratio is as follows:
The supervising physician will not supervise more than four PAs at one time.

Physician Assistant: When a Physician Assistant is required to be credentialed, a Delegation of Services Agreement will be required, which outlines the authorized services to be performed by the Physician Assistant when acting under the Supervising Physician and will be approved by the Supervising Physician and Physician Assistant. A copy of the agreement is kept in the credentialing files of the Supervising Physician and Physician Assistant. At all times, the Supervising Physician must be physically or electronically available to the PA for consultation except in emergency situations. In cases of emergency, the Physician Assistant, to the extent permitted by the laws relating to license or certificate involved, may render emergency services to a patient pending establishment of contact with the physician.

3 Policy

Practitioners who fall within the Scope of Authorization and Action will undergo initial credentialing prior to appointment to the Arizona Priority Care panel. Practitioner credentials will be re-reviewed at the time of recredentialing every three (3) years.

4 Delegation of Decision-Making Authority

Arizona Priority Care may delegate authority for performing the function of credentialing to medical groups (MGs) or Independent Practice Associations (IPAs) in accordance with the mutually agreed upon document for each delegate. The agreement describes the responsibilities of the delegated entity and the activities that are delegated. Arizona Priority Care maintains responsibility for ensuring that the function is being performed according to its expectations, contracted Health Plan delegation agreements, NCQA standards, Medicare, and other Federal and State regulations by performing an annual delegated oversight audit of the MG/IPAs and reviewing MG/IPAs submitted reports.

Arizona Priority Care Credentialing Department reports activities to the Arizona Priority Care Quality Improvement Committee (QIC). The QIC is responsible to:

- Evaluate the delegated MG/IPAs capacity to perform the delegated activities prior to delegation.
- Evaluate annually whether the delegated MG/IPA's activities are being conducted in accordance with Arizona Priority Care expectations, contracted health plan delegation agreements, NCQA standards, Medicare, and other State and Federal regulations.
- Obtain reports semi-annually from the delegated MG/IPAs activities on its progress in conducting credentialing and re-credentialing activities and the actions carried out to improve performance.
- Revoke delegation if the MG/IPA does not fulfill its responsibilities.
- To identify and follow-up on opportunities for improvement in each of the MG/IPAs credentialing processes at least once in each of the past two years.
- Arizona Priority Care has the right, based on quality issues, to approve, suspend or terminate individual practitioners, providers and sites in situations where Arizona Priority Care has delegated decision-making. Arizona Priority Care does not need to review each individual practitioner credentialed by the MG/IPA.

5 Annual Review

AZPC will annually review, revise as necessary, and approve the Credentialing Plan.

AZPC will, on an ongoing basis, assess the credentialing/recredentialing process through oversite audits or other assessment tools as applicable. Areas for improvement may be identified and opportunities and/or goals may be discussed for future implementation. Heritage Provider Network may perform annual review of AZPC; corporate oversite may be completed as well.

6 Practitioners' Rights and Responsibilities

6.1 Right to Review Information

The practitioner has the right to review information obtained by AZPC for the purpose of evaluating the practitioner's credentialing/recredentialing application. This includes information obtained from outside sources, e.g., state licensing boards. The practitioner will not be permitted to review peer references/recommendations or any other information protected from disclosure by law. The practitioner may schedule an appointment to review such information by sending a written request to the Medical Director.

6.2 Right to Correct Erroneous or Variant Information

The practitioner has the right to correct information that is believed to be erroneous. When information received from a primary source substantially varies from information provided on the practitioner's application, the Credentialing Department will contact the practitioner and request either verbally or in writing to provide an explanation.

Examples of information with substantial variance include reports of a practitioner's malpractice claims history, actions taken against a practitioner's license/certificate, suspension or termination of hospital privileges or board certification expiration when one or more of these examples have not been self-reported by the practitioner on his/her application. Sources will not be revealed if the information received is not intended for verification of credentialing elements or is protected from disclosure by law. Documentation, which may include re-verification from the primary source, will be kept in the credentialing file.

The practitioner will be given a 30-day time period in which to respond to the request for clarification of any discrepancy. The response must be in writing and submitted to the Credentialing Department. The Credentialing Department will provide a receipt of the corrections to the provider. If the response by the practitioner is not received by the Credentialing Department in 30 days, it will be assumed that the practitioner has voluntarily withdrawn his/her application and a letter will be mailed to the practitioner stating their credentialing application has been withdrawn due to non-compliance.

6.3 Right to be Informed of Application Status

The practitioner has the right, upon request, to be informed of the status of their credentialing/recredentialing application. This update will verify documents received in support of the practitioner's application and pending requests required for the completion of the credentialing process. Specific information/comments made by peer references or other information protected by law will not be discussed with the practitioner.

6.4 Practitioner's Burden to Produce Information

The practitioner has the burden to produce information for an adequate evaluation of the practitioner's qualifications and suitability for participation, of resolving any reasonable doubts about these matters, and of satisfying requests for information. Failure to produce information could cause delay and/or eventual termination of the application process.

6.5 Notification of Practitioner's Rights

Notification to the practitioner of their right to review information, right to correct erroneous or variant information, right to be informed of application status, and burden to produce information is included on AZPC's Information Release, which is part of the credentialing/recredentialing process.

7 Confidentiality

7.1 Confidentiality Statements

All credentialing staff members and Credentialing Committee members are required to sign a Confidentiality Agreement and Affirmative Statement on an annual basis (See attachment "A"). Health plan representatives are required to sign a Confidentiality Agreement before viewing confidential credentialing or peer review documents.

7.2 Employee Orientation

All new employees will receive orientation on the confidentiality of provider credentialing information regarding the rules and requirements as it relates to their job function in the Credentialing Department. Human resources will track evidence and acknowledgement of credentialing training in the employee's personnel file for the length of employment and for a period of ten (10) years following termination of employment. Ongoing education will be provided on an annual basis to the current staff.

7.3 Storage of Credentialing Files

To ensure confidentiality of paper credentialing file contents, all files are labeled "Confidential" and kept in locked file cabinets inside a locked Credentialing office, if applicable. Access is limited to authorized credentialing staff, and after hour access is only permitted when a supervisor is on the premises. Access to AZPC offices is allowed with an FOB or access code.

7.4 Information Systems/Electronic Security

Practitioner data is maintained using confidential information systems. The information system is located in a secure room with limited access during and outside of business hours. Additional security is also provided by the building owners/leases limiting access to the general office space.

CRD-013 Credentialing System Controls policy specifies the level of position/staff allowed to conduct certain activities within the application. Authorized credentialing staff is the only personnel permitted to access, view and update practitioner information. E-mail communication regarding confidential information is limited and used with caution. Methods to ensure confidentiality of electronic and systems information include, but not limited to, firewall and password protection, including intermittent password changes, assignment of appropriate authorization levels for each user and the withdrawal of passwords when an employee leaves the organization.

The credentialing software has the ability to track when changes are made to credentialing information and to generate historical activity logs to determine who accessed what credentialing files and when and what actions were taken. All information added or changed in the system is backed up nightly and held in the data warehouse. Reports are generated ensuring successful back up completion.

7.5 Accessing Credentialing Information

Internal: Internal access is permitted to the Medical Director and other Credentialing Committee members for necessary credentialing/recredentialing purposes. Suspected breach of confidentiality or violations by medical staff members will be reported to the Medical Director, which may prompt an investigation and disciplinary action. Suspected violations by an employee will be referred to the Medical Director for review and appropriate action pursuant to Human Resources policies.

External: Upon request to the Credentialing Department, information may be provided to contracted health plans, hospitals and Arizona Priority Care's Executive Committee and QIC for necessary credentialing/recredentialing purposes. AZPC requires authorization from the provider prior to the release of any credentialing information unless otherwise permitted or required by law.

Practitioner: Upon request to the Medical Director, access is provided to an applicant or participating practitioner who would like to review information submitted in support of their application. This includes information submitted from outside primary sources but does not include information protected from disclosure by law. Reviews will be accomplished in the Credentialing Department during normal business hours or otherwise under conditions designed to provide reasonable protection of the confidentiality of the records. Requests for copies will be considered on an individual basis.

Health Plan: Health plan representatives are permitted to view credentialing information and de-identified peer review/disciplinary action activities for the purpose of pre-contractual delegation and oversight of delegated functions. On-site audits by health plans may be scheduled at a time and date mutually agreed upon by the health plan and AZPC. Copied or faxed credentialing files may be provided to health plans for the purpose of an accreditation or state/federal regulatory audit (i.e., NCQA, CMS, ADHS). Credentialing files will not be copied or faxed for the purpose of "desktop" or "mock" audits.

7.6 Disposal of Confidential Credential Information

AZPC acknowledges an ethical and legal responsibility to protect the privacy of our providers. Consequently, all provider-identifiable information will be protected against indiscriminate and unauthorized access. AZPC will use reasonable care to preserve providers' right to privacy within the law. Any provider-identifiable information determined to be appropriate for disposal must be discarded in the manner according to the "Disposal of Protected Information Policy". Inappropriate use of this disposal procedure or willful disregard of this policy is a serious offense and will constitute cause for corrective action up to and including termination.

8 Delegated Activities

AZPC does not delegate or sub-delegate any activities described in the Credentialing Plan to any Credentialing Verification Organizations (CVO).

9 Credentialing Committee

A peer review process is established by designating a Credentialing Committee that includes representation from a range of participating practitioners.

9.1 Composition

Medical Director or Designee (Chairperson): The Medical Director or designee is a licensed physician in the State of Arizona and serves as the Credentialing Committee Chairperson and is responsible for the credentialing process. The Chairperson presides over Credentialing Committee meetings and is responsible for evaluating recommendations and initiating credentialing actions in a nondiscriminatory manner with regards to the qualifications and practice patterns of applicants and participating practitioners. The Chairperson has the authority to call an ad hoc committee and reports Credentialing Committee activity to the Quality Improvement Committee and Peer Review Committee, as applicable.

Medical Staff Representation: The Credentialing Committee is multidisciplinary in structure with representation from various types of practitioners and specialties. A minimum of three physician members is required for a quorum, which is inclusive of the Chairperson and two practicing physicians. Only physicians have voting rights on medical interpretation and peer review activities. Because not every specialty can be represented, at the discretion of the committee, meaningful advice may be sought from various practitioners and specialties to assist with the decision-making process.

Credentialing Staff Representative: The credentialing representative is responsible for timely completion of credentialing components, organizing the Credentialing Committee meeting, presentation of credentialing files to the Credentialing Committee for review and Credentialing Committee meeting minutes.

Quality Improvement Representative*:* The Quality Improvement representative is responsible for providing performance evaluation data and results to the Credentialing Committee for review.

Administrative and Departmental Representation: Administrative and other departmental representation are decided by the voting members.

9.2 Function

The Credentialing Committee will perform the following functions:

- Reviews and approves the Credentialing Plan, Corrective Action Plan and Judicial Review Hearing Plan as necessary, at a minimum on an annual basis.
- Ensures credentialing standards are being carried out for all practitioners who fall within the Scope of Authorization and Action.
- Approves and denies requests for credentialing applications.
- Reviews credentials of all new practitioners and participating practitioners every three years.
- Reviews credentials of all new and participating Healthcare Delivery Organizations (HDO's) every three years.
- Uses a peer review process to make decisions in a nondiscriminatory manner regarding approval, denial and disciplinary actions.
- Ensures final decisions are well documented in Credentialing Committee minutes.

9.3 Meeting Frequency

The Credentialing Committee will meet on a bi-monthly (every 2 months) basis, unless otherwise specified by physician voting members or in the committee charter. Meetings and decision making may take place in the form of real-time virtual meetings (e.g., video conferencing, WebEx). Meetings may not be conducted through email.

9.4 Reporting

Internal: The Credentialing Committee Chairperson reports activity to the Quality Improvement Committee and Peer Review Committee, as applicable.

External: The Credentialing Department submits biannual reports to health plans, HPN, Executive Committee, and QIC as required by delegation agreements.

AZPC complies with the reporting requirements of the Arizona Medical Board, National Practitioner Data Bank, and Federal Health Care Quality Improvement Act regarding adverse credentialing and peer review actions. Please refer to the Corrective Action Plan and Judicial Review Hearing Plan for further policies and procedures.

10 Eligibility Criteria

A qualifying practitioner must meet the following eligibility criteria. If at any time it is determined that the practitioner does not meet criteria, the Credentialing Department will notify the practitioner of his/her lack of qualifications and terminate the credentialing process. A provider may not provide care to enrollees until a final decision is rendered from the Credentialing Committee. Credentialing department will notify the provider of the decision within 60 days from when the completed credentialing application is received

State Licensure
Valid, current professional licensure issued by an appropriate board in the State of Arizona.

DEA or CDS Certification
Valid, current DEA or CDS Certification (if applicable) registered with an Arizona address.

National Provider Identifier (NPI)
Valid, current NPI.

Education and Board Certification
At the time of initial application, an applying practitioner must meet this criterion by either one of the following:

- Graduation from a professional school (allied and behavioral health practitioners only), school of medicine, osteopathy, chiropractor or dentistry.
- Completion of Internship and Residency training in good standing in the practitioner's practicing medical or surgical specialty, as applicable.
- Board Certification by the American Board of Medical Specialties, American Osteopathic Association, a board or association with equivalent requirements approved by the Medical Board of Arizona, or a board or association with an Accreditation Council for Graduate Medical Education or American Osteopathic Association approved postgraduate training that provides complete training in that specialty or subspecialty.
- Exceptions may be made for those practitioners who are grandfathered into their specialty under special circumstances. (i.e.: Family Practice Board 1970-1978).
- Exceptions may also be made for rural areas. Work history and professional training will be reviewed for these practitioners.

Clinical Privileges

Current, unrestricted clinical privileges that are consistent with the practitioner's practicing medical or surgical specialty, as applicable.

** This requirement may be waived if acceptable inpatient coverage arrangements are made. Practitioner(s) providing such coverage will have met all established credentialing eligibility criteria and participate on the AZPC's panel.*

Hospital Privileges

Absence of past or present denial, suspension, restriction or termination of hospital privileges.

** This requirement may be waived if evidence exists that any such action does not adversely affect the practitioner's ability to perform his or her professional duties.*

Malpractice Insurance

Current professional malpractice insurance with minimum coverage of:

- MDs, DOs, DDSs, DPMs, Allied Health Practitioners, Behavioral Health Practitioners and Nurse Practitioners: $1,000,000 per occurrence, $3,000,000 aggregate

Liability coverage must be provided by a recognized financially viable carrier and must be in the specialty for which the provider is being credentialed for. If a practitioner does not have malpractice insurance within the limits, it must be discussed at the committee and the decision must be documented .

Malpractice Involvement

Absence of past or present involvement in a malpractice suit, arbitration or settlement.

** This requirement may be waived if evidence exists that involvement does not adversely affect the practitioner's ability to perform his or her professional duties.*

Disciplinary Actions

Absence of past or present disciplinary actions affecting the practitioner's professional licensure, DEA or other required certification.

** This requirement may be waived if evidence exists that any such action does not adversely affect the practitioner's ability to perform his or her professional duties.*

Sanctions

Absence of past or present sanctions by regulatory agencies, including Medicare sanctions.

** This requirement may be waived if evidence exists that the practitioner is not currently sanctioned or prevented by a regulatory agency from participating in a federal or state sponsored program.*

Medicare Opt Out

Absence of past or present voluntary "opt-out" from Medicare participation. AZPC will not contract or employ practitioners who have opted opt out of Medicare.

Medicare Exclusions and Sanctions

Absence of present exclusions or sanctions from Medicare. AZPC will not contract or employ practitioners (or entities that employ or contract with such practitioners) that are excluded/sanctioned from participation in Medicare and found on the OIG report.

Felony Convictions

Absence of felony convictions.

** This requirement may be waived if evidence exists that conviction does not adversely affect the practitioner's ability to perform his or her professional duties.*

Illegal Use of Drugs

Absence of present illegal use of drugs.

Impairment

Absence of impairment or likely impairment of practitioner's ability to adequately perform the professional duties for which the practitioner is employed or contracted, with or without reasonable accommodation, according to the accepted standards of professional performance and without posing a direct threat to the safety of patients.

Office Site Visit

Satisfactory results of office site visit, including medical record review, as applicable.

Language

Proficient in the English language.

11 Primary Source Verification

Primary Source Verification ("PSV") of practitioner credentials will be written, oral or via internet website. Verifications will be no more than 180 calendar days old at the time of credentialing decisions.

- Written verifications must come directly from the Arizona State Licensing Agency and the printed date on the document will be used to calculate the 180-day timeline, not the date received.
- Oral verifications will be documented by a dated, signed note in the credentialing file stating the information was verified, who verified the information, and how it was verified.
- Internet website and electronic verifications (via web-crawlers which are software that retrieve information directly from a website and save it in the credentialing application) will come from the appropriate state agency and will be dated by the credentialing staff member who verified the information, based on the system recorded date of the web-crawl (receipt date). The PSV documents are stored in the electronic credentialing system which tracks the date and user ID any time the document is accessed, changed, or removed.

AZPC will re-verify credentialing factors that are no longer within the credentialing time limits and those that will be effective at the time of the Credentialing Committee's review.

12 Credentialing Application

Acceptable applications include Arizona Priority Care credentialing application or CAQH Online Credentialing Application Database Service.

For mental and behavioral health providers, upon receipt of the application by the credentialing department, the applicant will be notified within seven business days, to verify receipt and inform the applicant whether the application is complete. A determination will be made within 60-days of receipt of the completed application.

Applicant Attestation - Verification Time Limit - 180 calendar days
The signature on the acceptable applications and any relevant information may not be older than 180 calendar days at the time of the Credentialing Committee's action. If the signed attestation exceeds 180 calendar days before review and action by the Credentialing Committee, the practitioner will have the opportunity to update it. The practitioner will be sent a copy of the completed application with the new attestation form requesting to update the application and attest that the information on the application is correct and complete. The practitioner will not be required to complete another application. The attestation will address:

- Reasons for any inability to perform the essential functions of the positions, with or without accommodation
- Lack of present illegal drug use
- History of loss of license and/or felony convictions
- History of loss or limitation of privileges or disciplinary action
- Current malpractice insurance and amount of coverage
- Correctness and completeness of application

Supporting Documentation
The following items may be requested in support of the application, as applicable:

- Current curriculum vitae
- Copy of valid, current professional licensure issued by the State of Arizona
- Copy of valid, current DEA or CDS Certificate
- Copy of valid, current board certificate or letter from the certifying board announcing certification
- Copy of valid, current malpractice face sheet that includes coverage limits and expiration date
- Copy of ECFMG certificate

13 Initial Credentialing Procedure

Upon receipt of an application by the Credentialing Department, the application will be reviewed for completeness. The signed attestation and any relevant information must be no more than 30 days old to allow adequate processing time. Faxed, digital, electronic, scanned or photocopied signatures are acceptable. Signature stamps are not acceptable. An incomplete application will be returned to the applicant.

13.1 Verifications

State Licensure (Verification Time Limit - 180 calendar days, PSV)
Valid, current professional licensure issued by an appropriate board in the State of Arizona. Confirmation that the practitioner holds a valid, current license to practice will be verified from the appropriate state licensing board in writing, verbally or via internet website.

DEA or CDS Certification (if applicable, Verification Time Limit - 180 calendar days, PSV)
Valid, current DEA will be verified by obtaining a copy of the current DEA certificate, visual inspection of the original DEA certificate, or confirmation from the state pharmaceutical licensing agency where applicable. The address on the DEA certificate should display a valid Arizona address.

DEAs with a non-Arizona address will be verified and credentialed with a written explanation. The documented explanation must include how the practitioner is in the process of updating and/or obtaining an Arizona specific certificate within 90 days of credentialing.
** A pending DEA certificate is acceptable if there is a well-documented process in place naming another practitioner holding a valid, current DEA certificate to write all prescriptions until the practitioner's DEA has been processed.*

If a qualified practitioner, under the scope of credentialing, does not have a valid DEA, a document must be maintained in the credentialing file naming another practitioner holding a valid, current DEA certificate to write all prescriptions.

Chiropractors: DEA certificates are not applicable.

NPI (Verification Time Limit - 180 calendar days, PSV)
Valid NPI type 1 (Individual) issued by National Plan and Provider Enumeration System (NPPES) will be verified via NPPES website.

Education (PSV)
The highest of the three levels of education and training obtained by the practitioner are verified.

- Graduation from medical or professional school
- Residency, if appropriate
- Board certification, if appropriate (Note: An expired board certification may be used to verify education and training)

Below are the levels of education for particular provider degree:

- Physicians (MD's and DO's): residency regardless of specialty, or if no residency is completed, Medical School, and if applicable, fellowship in specialty to practice, will be verified by confirmation from the medical school/training program, AMA Master File, AOA Physician Profile Report or Master File, or state licensing agency. Medical school may also be verified by ECFMG for foreign medical graduates after 1986.
- DC's: graduation from Chiropractic College
- DDS's: graduation from dental school and Commission on Dental Accreditation (CODA) accredited specialty training
- DPM's: graduation from podiatry school and specialty training
- Non-physician healthcare practitioners: graduation from professional school
- NP's and PA's: certification from American Nurses Credentialing Center (ANCC) and National Commission on Certification of Physician Assistant (NCCPA)

When a non-physician certifying board or state licensing agency is used for verification of education and training, annual written verification will be kept on file in the Credentialing Department that primary source verification is conducted of professional education and training.

If the practitioner submits transcripts to AZPC that are in the institution's sealed envelope with an unbroken institution seal, AZPC will accept this as primary source verification for education and training. AZPC will provide evidence that they have inspected the contents of the envelope and confirmed that the transcript shows that the provider completed (graduated from) the appropriate training program.

If a physician states that education and training were completed through the AMA's Fifth Pathway Program, AZPC will confirm it through primary source verification from the AMA.

Education references on a practitioner's CV must include the month and year the education was received. Future dates of any program cannot be accepted.

Board Certification (Verification Time Limit - 180 calendar days, PSV)
If the practitioner states that he or she is board certified on the application, verification of good standing in the specialty they are practicing will be obtained using the most current data available from one of the following sources: an official ABMS Display Agent -www.boardcertifieddocs.com or https://certifacts.abms.org, where a dated certificate of primary source authenticity has been provided; AOA Official Osteopathic Physician Profile Report or AOA Physician Master File; confirmation from the appropriate specialty board; AMA Physician Master File or confirmation from the state licensing agency if the state agency conducts primary verification of board status. Foreign board certification can be confirmed by obtaining a letter from the Accreditation Council for Graduate Medical Education (ACGME) that states the foreign board receives primary source verification of education and training for every board-certified practitioner.

The ABMS Certified Doctor Verification Program, accessible through the ABMS website, is intended for consumers only and is not an acceptable verification source for board certification.

- Chiropractors: Board certification does not apply.
- Oral Surgeons: Board certification can be confirmed from a Commission on Dental Accreditation accredited specialty board but cannot be substituted for the verification of dental education and specialty training.
- Podiatrists: Board certification can be confirmed from the appropriate specialty board or podiatry specialty board if there is evidence that the board conducts primary source verification of podiatry school graduation and completion of residency.
- Non-Physician Health Practitioners: Board certification can be confirmed from the specialty board but cannot be substituted for the verification of education and training.

Clinical/Hospital Privileges (If applicable, Verification Time Limit - 180 calendar days, PSV not required)

Clinical privileges in good standing in the specialty that the practitioner is being credentialed at, the hospital designated by the practitioner as the primary admitting facility will be verified in writing, verbally, via hospital roster, an/or physician application form. Confirmation will include status, date of appointment, restrictions and recommendations. Acceptable status for clinic privileges is Active, Courtesy, Associate, Temporary, and Provisional. If any other status is been used as the acceptable status, a written document defining the status will be obtained from the facility at least on an annual basis.

Hospital rosters (Medical Staff Rosters) may be used only if they include necessary information (name, specialty, appointment date) and are accompanied by a dated letter from the hospital attesting that all practitioners listed are in good standing.

If the practitioner does not have clinical privileges, an explanation of the practitioner's inpatient coverage arrangement is required. Practitioner(s) providing such coverage must be credentialed AZPC practitioners, if applicable. The practitioners providing coverage must be in the same specialty and same practice to avoid delay in care. Documentation of such coverage will be kept in the credentialing file and also be communicated to the practitioner. Such communication will include the notification date, the name of the admitting practitioner and/or hospitalist, and the list of hospitals.

Malpractice Insurance (PSV not required)

Malpractice liability insurance is verified by a copy of the practitioner's current malpractice insurance face sheet which includes effective dates, amounts of coverage and specialty, as defined in the Eligibility Criteria Section. Evidence of private malpractice insurance coverage or employer professional liability policy must include a roster of all individuals in the practice who ae covered under the policy.

Malpractice History (Verification Time Limit - 180 calendar days, PSV)

Malpractice settlements or judgments during the past five (5) years paid by or on behalf of the practitioner is confirmed in writing from the malpractice carrier or the NPDB is queried.

In some instances, the five (5) year period may include residency or fellowship years. It is not necessary to obtain confirmation from the carrier for practitioners who had a hospital insurance policy during a residency or fellowship

Work History (Verification Time Limit - 180 calendar days, PSV not required)
Work history for the past five years is included on the practitioner's application, curriculum vitae, or listed separately as "Work History." Gaps six (6) months or more in time will be verbally clarified and documented as a verbal verification. Gaps of one year or longer are clarified in writing.

The work history must include the beginning month, ending month and year for each listed work experience.

If the practitioner completed his/her education and went straight into practice, this will count as continuous work history.

Office of Inspector General (OIG) (Verification Time Limit - 180 calendar days, PSV)
Confirmation that the practitioner is not listed on the List of Excluded Individuals and Entities (Maintained on the Office of Inspector General website).

System for Award Management (SAM) (Verification Time Limit - 180 calendar days, PSV)
Confirmation that the practitioner is not listed on the Excluded Parties Lists System using System for Award Management (SAM) website.

Social Security Death Master File (SSDMF) (Verification Time Limit - 180 calendar days, PSV)
Confirmation that the practitioner is not listed on the Social Security Death Master File (maintained by Social Security Administration), to determine if practitioner is using a deceased person's identity.

CMS Preclusion List (Verification Time Limit - 180 calendar days, PSV)
Confirmation that the practitioner is not listed on the CMS Preclusion List (maintained by CMS Medicare and provided by health plan), to determine if practitioner has been precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare recipients.

Office Site Review and Medical Record Review (if applicable) (Not a delegated function to AZPC)
A current office site and medical record review by the health plan will be required for all primary care practitioners (GP/FP/IM/OBGYN) and high-volume behavioral health practitioners. The review will be performed prior to the Credentialing Committee review and must have a passing score of at least 90%. Office site and medical record review documents will be downloaded from health plan website. If the health plan does not have a current office site review and medical record review, the health plan's

provider Network Development Department will be notified for an office site review and medical record review.

13.2 Information from Designated Organizations

Information received from designated organizations will be no more than 180 days old at the time of Credentialing Committee review and decision.

National Practitioner Data Bank (NPDB)

To receive information on claims that have resulted in settlements or judgments, the National Practitioner Data Bank will be queried. To receive information on healthcare practitioners, providers and suppliers regarding criminal convictions, civil judgments, exclusion from government healthcare programs, State and Federal licensure actions, as well as other adjudicated actions.

State Board Queries

To receive information regarding past or present state sanctions and restrictions on licensure and/or limitations on scope of practice, the following queries will be made to obtain information during the most recent five (5)-year period:

- Physicians (MD's and DO's): National Practitioner Data Bank.
- DC's: State Board of Chiropractic Examiners, NPDB or Federation of Chiropractic Licensing Boards' Chiropractic Information Network-Board Action Databank (CIN-BAD).
- DDS's: State Board of Dental Examiners, NPDB.
- DPM's: State Board of Podiatric Examiners, NPDB or Federation of Podiatric Medical Boards.
- Non-physician Healthcare Professionals: Appropriate state agency, NPDB or state board of licensure or certification.

Medicare Opt-Out Report

To determine if the practitioner has opted out of Medicare, the latest report from Medicare will be checked using CMS.gov.

Office Site Review for Complaints

AZPC has established performance standards and thresholds for a practitioner's office regarding the physical accessibility, the physical appearance, the adequacy of waiting and examining room space and adequacy of medical/treatment record keeping.

Complaints regarding physical accessibility, physical appearance and adequacy of waiting and examining room accessibility to equipment, adequacy of medical/treatment records keeping and confidentiality will be brought forth to the Credentialing Committee to determine the severity of the complaint and if a site visit is warranted. These complaints will be tracked and trended by the Quality Department. Two or more complaints on the same provider will warrant a site visit. If the Committee deems that a site visit is required, the visit will be performed within 60 days of the receipt of the complaint. Complaints regarding the adequacy of equipment warrant an automatic site visit. The office will be surveyed according to that corresponding section in the Office and Facility Survey with Corrective Action Plan Tool.

If a deficiency is found, a Corrective Action Plan for improvement will be required for all items that do not meet thresholds. Follow-up of those identified deficiencies will take place at least every six months until deficiencies are resolved, which may include a re-evaluation of the site. The follow-up actions and practitioner responses will be documented in the practitioner's credentialing file.

Scoring:
The office site review initiated via a complaint and medical record review are evaluated against set standards and thresholds set forth by AZPC and will be based on a point system indicating percentage of compliance.

The office site and medical record review are scored and totaled according to the following guidelines:

Approved:	**90%**
Corrective Action Plan:	**≤ 89%**

All complaints triggering a site visit will be captured on the Office and Facility Survey with Corrective Action Plan Tool and reviewed by the Credentialing Committee annually.

If another complaint about the same office site is received within one year regarding the same office-site criteria standard, a follow-up site visit will be conducted within 60 calendar days but only those elements will be reviewed. If another complaint is received regarding a different office site criteria standard, then another site visit will be performed within 60 calendar days. Member complaints will be monitored for all practitioner sites at least every six months. When appropriate, complaints will be forwarded to the applicable health plan upon receipt.

Qualifications of Staff Performing the Site Review for Complaints
AZPC has established that properly trained and appropriately qualified staff is capable of conducting site audits arising from complaints. The following qualification requirements for the staff conducting site audits arising out of a complaint(s):

- A licensed LPN or RN and
- Completion of the Office and Facility Survey with Corrective Action Plan Training Guide

14 Recredentialing Criteria

A formal recredentialing process is required every three (3) years with the process being completed within the month of the recredentialing date. There is no grace period beyond the 36-month allotted time period to re-verify information that may have changed over time. The three-year cycle begins with the date of the initial credentialing decision date and thereafter three years from the recredentialing decision. A practitioner cannot be re-credentialed if the time is past the recredentialing date month.

Exceptions

If AZPC cannot recredential a practitioner within the 36-month time frame because the practitioner is on active military assignment, maternity leave or a sabbatical but the contract between AZPC and the practitioner remains in place, AZPC may recredential the practitioner upon his or her return. AZPC must document the reason for the delay in the practitioner's file.

At the minimum, AZPC must verify that a practitioner who returns from military assignment, maternity leave or a sabbatical has a valid license to practice before he or she resumes seeing patients. Within 60 calendar days of when a practitioner resumes practice, AZPC must complete the recredentialing cycle. On the other hand, if either party terminates the contract, or there is a break in service of more than 30 calendar days, AZPC must initially credential the practitioner before the practitioner rejoins the network.

If a practitioner is given administrative termination for reasons beyond AZPC's control (e.g., the practitioner failed to provide complete credentialing information) and is then reinstated within 30 calendar days, AZPC may recredential the practitioner as long as it provides documentation that the practitioner was termed for reasons beyond its control and was recredentialed and reinstated within 30 calendar days of termination. AZPC must initially credential the practitioner if reinstatement is more than 30 calendar days after termination.

15 Recredentialing Application

Acceptable applications include Arizona Priority Care recredentialing application or CAQH online credentialing application database service.

Applicant Attestation - Verification Time Limit - 180 calendar days
The recredentialing application includes a current and signed attestation by the applicant and addresses the following:

- Reasons for any inability to perform the essential functions of the position, with or without accommodation
- Lack of present illegal drug use
- History of loss of license and/or felony convictions
- History of loss or limitation of privileges or disciplinary action
- Current malpractice insurance and amount of coverage
- Correctness and completeness of application

Supporting Documentation
The following items may be requested in support of the application, as applicable:

- Copy of valid, current professional licensure issued by the State of Arizona
- Copy of valid, current DEA or CDS certificate
- Copy of valid, current board certificate or letter from the certifying board announcing certification
- Copy of valid, current malpractice face sheet that includes coverage limits and expiration date

16 Recredentialing Procedure

A tickler file in the form of a checklist, spreadsheet or computer-generated report alerts credentialing staff of practitioners due for recredentialing. One hundred eighty (180) days prior to expiration of the three-year (36-month) cycle, the practitioner is mailed or faxed a recredentialing letter. The 36-month cycle begins with the date of the initial credentialing decision and is counted to the month, not the day.

Upon receipt, the signed attestation by the applicant should be no more than 30 days old to allow for adequate processing time. Faxed, digital, electronic, scanned or photocopied signatures are acceptable. Signature stamps are not acceptable. If the CAQH is incomplete, the practitioner will be notified.

16.1 Verification

- State Licensure (verification time limit - 180 calendar days, PSV)
- DEA or CDS Certification (If applicable, verification time limit - 180 calendar days, PSV)
- NPI (verification time limit - 180 calendar days, PSV)
- Board Certification if newly certified or recertified in the past three years/36 months (verification time limit - 180 calendar days, PSV)
- Clinical/Hospital Privileges (If applicable, PSV not required)
- Malpractice Insurance (PSV not required)
- Malpractice History (verification time limit - 180 calendar days, PSV)
- Office of Inspector General (OIG) (verification time limit - 180 calendar days, PSV)
- System of Award Management (SAM) (verification time limit - 180 calendar days, PSV)
- CMS Preclusion List
- Social Security Death Master File (SSDMF)
- Office Site Review and Medical Record Review (If applicable) (Not a delegated function)
- Arizona Medicare Opt Out list (verification time limit - 180 calendar days, PSV)

16.2 Information from Designated Organizations

Same as Chapter I, Section 13.2.

16.3 Performance Monitoring

Information derived from the practice experience of all practitioners is incorporated into the recredentialing process and reviewed by the Credentialing Committee. At a minimum, confidential member complaint data, information from quality improvement activities, utilization management performance data and member satisfaction data will be used to assess professional performance, judgment and clinical competence and will be used in the recredentialing decision process. The data used for performance monitoring is obtained no earlier than 1 month prior to the Credentialing Committee.

17 Credentialing Committee Review and Action

In preparation for Credentialing Committee review, an internal audit of credentialing file contents is performed to ensure all information is present and received within the required timeframes. Each item is

recorded on a Credentialing Committee preparation checklist, which includes a brief summary of the file and identifies, if any, "red flag" (adverse or unfavorable) issues for committee review. The preparation checklist is signed by both the credentialing staff member who prepares the file and a physician-voting member upon final decision. For those files that the committee decides should include more information, the file will be pended and the committee will re-review the file at a later date. At that time the committee will evaluate the credentials, offer advice if necessary and make a final decision regarding the practitioner. All of the information in the file must meet NCQA timeliness requirements. If any information is out of date, it will be re-verified before brought to Committee for review.

Completed credentialing files will be divided into two categories: (1) Routine/Clean File Review (2) Intensive Review. The files will be scheduled for review at an upcoming Credentialing Committee meeting.

17.1 Routine/Clean File Review

Credentialing files **without** adverse or unfavorable credentialing/recredentialing findings that meet established criteria.

Clean File Review criteria for the credentialing process:

- NPDB reports no disciplinary actions/malpractice payments
- NPDB reports no criminal convictions, civil judgments, exclusions from government health care programs, state and federal licensure actions, as well as other adjudicated actions
- No record of malpractice payments during the previous five (5)-year period for the initial credentialing process and three (3)-year period for subsequent recredentialing cycles
- No licensure restrictions
- Good standing at reputable hospital or stated inpatient coverage arrangement that meets criteria
- No time gaps
- Information returned in a timely manner and contains nothing to suggest that the practitioner is anything other than highly qualified in all areas; and,
- Passing score on office site visit, including medical record review (if applicable)
- No identified member complaint data, quality improvement activity or utilization management performance problems for recredentialing

A Medical Director or an equally qualified practitioner designated by the Credentialing Committee has the authority to review and sign off on clean files which have met AZPC credentialing or recredentialing criteria. The date the file is signed by the Medical Director is the date that will be considered the “Committee Review Date”. These files do not have to be reviewed by the Credentialing Committee to be approved.

17.2 Intensive Review

Credentialing files **with** adverse or unfavorable credentialing/recredentialing findings that meet established criteria.

Intensive Review criteria for the credentialing process:

- NPDB reports disciplinary actions or malpractice payments
- NPDB reports criminal conviction, civil judgment, exclusion from government health care program, state and federal licensure action, or other adjudicated action
- Licensure restrictions or licensed in more than five (5) states in five (5) years (a lot of moving around, excluding military)
- Many hospital affiliations in a short time period (unless this would be expected, given the practitioner's specialty and the area in which he/she practices) or information provided from hospital affiliations is "guarded" or suggests problems
- Time gaps (identified from application and work history form)
- Difficulty obtaining information
- Identified member complaint data, quality improvement activity or utilization management performance problems for recredentialing

Intensive Review credentialing files will be presented to the Credentialing Committee for intensive review. Possible action by the Credentialing Committee includes approval, denial, recommendation for improvement and/or monitoring, disciplinary action or request for further information. These files require two signatures for approval.

All credentialing files regardless of Routine/Clean File Review or Intensive Review criteria are brought to the Credentialing Committee. Possible action by the Credentialing Committee includes approval, denial, recommendation for improvement and/or monitoring, disciplinary action or request for further information.

18 Nondiscriminatory Credentialing/Recredentialing

Credentialing/Recredentialing decisions are not based on a practitioner's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures (e.g., abortions) or types of patients (e.g., Medicaid) to which the practitioner provides services. This will not preclude actions regarding practitioners who meet certain demographic or specialty needs or to meet cultural needs of members. AZPC monitors and prevents discriminatory credentialing through the following process:

- The presence of a nondiscrimination statement on the "Confidentiality Agreement and Affirmative Statement" to be signed by members, staff and guests of the Credentialing Committee on an annual basis.
- Audits of practitioner complaints will be done on a quarterly basis to determine if there are complaints alleging discrimination.

Documents and/or information submitted to the Credentialing Committee for approval, denial or termination do not designate a practitioner's race, ethnic/national identity, gender, age, sexual orientation, types of procedures performed or payor sources.

19 Provisional Credentialing

Provisional credentialing is acceptable under very limited circumstances and is only available to practitioners who are applying to AZPC for the first time A practitioner can only be provisionally credentialed once. Practitioners who have been in the organization's network via delegation arrangement are not eligible for provisional credentialing by the organization if the delegation arrangement is terminated or if the practitioner is no longer affiliated with the delegate. Provisional status expires after 60 days and cannot be renewed.

The Credentialing Committee bases provisional credentialing actions on the following information:

- Primary Source verification of a current valid license to practice
- Primary Source verification of the past five years of malpractice claims or settlements from the malpractice carrier or the results of the NPDB query.
- A current and signed application with attestation.

Each factor must be primary source verified within one hundred eighty (180) calendar days of the Credentialing Committee decision. Provisional credentialing files must be valid and verified within the specified timeframes. Provisional credentialing files must contain a medical director or equally qualified practitioner sign off, if the file meets AZPC's definition of a clean file, or be presented to the Credentialing Committee for review and consideration for participation into the network.

20 Communication of Committee Action

The practitioner will be notified in writing within sixty (60) calendar days of Credentialing Committee's credentialing/recredentialing decision. A copy of the written correspondence will be kept in the credentialing file. Documentation of adverse decisions will be kept in a file.

21 Practitioner Termination and Reinstatement

If a practitioner receives an adverse decision which entitles the practitioner to a hearing, then that practitioner shall not be eligible to reapply until one (1) year after the adverse decision is final and the practitioner has exhausted all applicable hearing rights. If a practitioner terminates and later wishes to rejoin, the practitioner must undergo the initial credentialing process if the break in service is greater than 30 days. The credentials of the practitioner will be re-verified following the same guidelines as described in the Initial Credentialing Procedure and Credentialing Committee Review and Action. It is not required to re-verify credentials that do not expire, such as completion of education and training and board certification that is not time-limited.

22 Ongoing Monitoring

Ongoing monitoring documentation is centralized for AZPC via secured intranet located athttp://hpnweb1/msowreports. Any reported practitioners are immediately brought to the attention of

the Medical Director to address issues of continued practitioner participation and payment of Medicare claims. Evidence of ongoing monitoring can also be found in the Ongoing Monitoring Spreadsheet and the Credentialing Committee minutes.

22.1 Licensing Boards

Arizona Medical Board (AMB) Disciplinary Notifications: The e-mail notifications are reviewed within 30 days of their release to identify participating practitioners that have recent accusations or disciplinary actions. The e-mails will be reviewed, dated and initialed by credentialing staff as notified by AMB.

Arizona Board of Osteopathic Examiners (ABOE) Actions: The quarterly reports are reviewed within 30 days of their release to identify participating practitioners that have recent enforcement actions. The reports will be reviewed, dated and initialed by credentialing staff on a quarterly basis.

Arizona Board of Podiatry Examiners Disciplinary Actions: The monthly reports are reviewed within 30 days of their release to identify participating practitioners that have recent disciplinary actions. The reports will be reviewed, dated and initialed by credentialing staff on a monthly basis.

Arizona Board of Behavioral Health Examiners Enforcement Actions: The e-mail notifications are reviewed within 30 days of their release to identify participating practitioners that have recent enforcement actions. The e-mails will be reviewed, dated and initialed by credentialing staff on a quarterly basis.

Arizona Board of Psychology Examiners Enforcement Actions: The e-mail notifications are reviewed within 30 days of their release to identify participating practitioners that have recent enforcement actions. The e-mails will be reviewed, dated and initialed by credentialing staff on a monthly basis (if published).

Arizona Board of Chiropractic Examiners Disciplinary Actions: The monthly reports are reviewed within 30 days of their release to identify participating practitioners that have recent disciplinary actions. The reports will be reviewed, dated and initialed by credentialing staff on a monthly basis.

Arizona Acupuncture Board of Examiners Disciplinary Actions: The monthly reports are reviewed within 30 days of their release to identify participating practitioners that have recent disciplinary actions. The reports will be reviewed, dated and initialed by credentialing staff on a monthly basis.

Arizona State Board of Dental Examiners Disciplinary Actions: The monthly reports are reviewed within 30 days of their release to identify participating practitioners that have recent disciplinary actions. The reports will be reviewed, dated and initialed by credentialing staff on a monthly basis.

Arizona Board of Occupational Therapy Disciplinary Actions: The e-mail notifications are reviewed within 30 days of their release to identify participating practitioners that have recent accusations or disciplinary actions. The emails will be reviewed, dated and initialed by credentialing staff as notified.

Arizona State Board of Optometry Enforcement Actions: The monthly reports are reviewed within 30 days of their release to identify participating practitioners that have recent enforcement actions. The reports will be reviewed, dated and initialed by credentialing staff on a monthly basis.

Arizona State Board of Physical Therapy Enforcement and Disciplinary Actions: The monthly reports are reviewed within 30 days of their release to identify participating practitioners that have recent enforcement actions. The reports will be reviewed, dated and initialed by credentialing staff on a monthly basis.

Arizona Regulatory Board of Physician Assistants Enforcement Actions: The monthly reports are reviewed within 30 days of their release to identify participating practitioners that have recent enforcement actions. The reports will be reviewed, dated and initialed by credentialing staff on a monthly basis.

Arizona State Board of Nursing Enforcement Actions: The monthly reports are reviewed within 30 days of their release to identify participating practitioners that have recent enforcement actions. The reports will be reviewed, dated and initialed by credentialing staff on a monthly basis.

Arizona Department of Health and Human Services Speech and Hearing Advisory Committee Disciplinary Actions: The quarterly reports are reviewed within 30 days of their release to identify participating practitioners that have recent disciplinary actions. The reports will be reviewed, dated and initialed by credentialing staff on a quarterly basis.

Exceptions will be made when the boards do not update the reports in a timely fashion. Such information will be documented. If the board does not release sanction information reports for more than 12 months, individual queries for the providers belong to that board. Individual queries will be conducted every 6 months thereafter.

22.2 Medicare Sanctions and Exclusions

AZPC will only contract with or employ practitioners who are not excluded from or are not sanctioned by Medicare. The Office of Inspector General and System for Award Management (SAM)database is reviewed within 30 days of its release to identify participating practitioners who have been sanctioned or excluded from Medicare programs. The database will be reviewed, dated and initialed by credentialing staff on a monthly basis.

22.3 Medicare Opt-Out Report

AZPC will only contract with or employ practitioners who have not opted-out from Medicare or have not been excluded/sanctioned from participation in Medicare. The Medicare Opt-Out Provider Reports for Arizona are reviewed within 30 days of its release to identify participating practitioners who have opted out to provide services to Medicare recipients. The Medicare Opt Out report will be reviewed, dated, and initialed by credentialing staff on a quarterly basis.

22.4 CMS Preclusion List

AZPC will review providers who have been precluded from participating in Medicare program. The CMS Preclusion List are reviewed within 30 days of their release to identify participating practitioners who have been precluded to provide services to Medicare recipients. The CMS Preclusion List will be reviewed, dated, and initialed by credentialing staff on a monthly basis (when received from health plan).

22.5 Complaints - Problems at Sites - Adverse Events

Any complaint regarding physical accessibility, the physical appearance, the adequacy of waiting and examining rooms, and the adequacy of medical/treatment record keeping will be investigated and brought before the Credentialing Committee for review to determine if there is evidence of poor quality that could affect the health and safety of members and then implement appropriate actions/interventions. Other problems or identified adverse events that occur at the practitioner sites are detected by ongoing monitoring of reported member complaints and grievance data, and other means by which problems or adverse events are brought to the attention of administration and QI and UM staff (i.e., practice-specific member surveys and reports from Provider Relations visits).

Provider Complaint Monitoring: The Credentialing Committee will review the provider grievance logs, at a minimum, every six months. One or more complaints or grievances per provider other than those for physical accessibility, appears and the adequacy of waiting and examining rooms and equipment within a six-month period could indicate a visit to the practitioner's site for an office site evaluation, medical record audit, or submission of a Corrective Action Plan. If deficiencies are found upon the visit to the practitioner's site, a Corrective Action Plan for improvement will be implemented and/or follow-up site evaluations will be required until performance thresholds are met.

Adverse Event Monitoring: An adverse event is an injury that occurs while a member is receiving healthcare services from a provider. PQI's (Potential Quality Issues) are monitored on an ongoing basis. Adverse events (those leveled 4 or higher) of providers are monitored by the Quality Department and presented to the Credentialing Committee for review, at a minimum, every six months. When instances of poor quality are identified, appropriate interventions are implemented, as well as oversight of the corrective action and resolution. When necessary, the Medical Director may be involved to ensure that the problem or adverse event is corrected. If the problem or event is determined to require further review, the provider is subject to peer review and appropriate disciplinary action and follow-up (See the page 19 of the Quality Improvement Program).

22.6 Continuous Updates

Licenses and DEA Certifications (expirables) are kept current via ongoing monitoring by the AZPC's credentialing application (Morrisey) which automatically checks for license updates via the internet and stores it in the practitioner's file. The following steps are performed before and after expiration:

- The credentialing application checks for expired licenses ten (10) days before expiration. If the expirable is renewed, then the credentialing application captures the information and stores it in the practitioner's file. If the expirable is not renewed, then the credentialing application posts a notification to the employee work list to pull the verification manually.
- The credentialing application checks for the expirable one (1) day prior to expiration. If the expirable is renewed, then the credentialing application captures the information and stores in the practitioner's file. If the expirable is not renewed, then the credentialing application notifies the credentialing coordinator. The credentialing coordinator tries to resolve the issue with the practitioner and obtain necessary documentation. The Credentialing Committee is notified of such actions. If the provider has not renewed the expirable, the credentialing status is made inactive (terminated) immediately; the practitioner is notified and all the pertaining departments are notified.
- Malpractice insurance copies are obtained from the provider when the insurance copy on file expires.

23 Meeting Minutes

The Credentialing Committee's thoughtful consideration of credentials and actions taken are well documented in Credentialing Committee minutes. Minutes are approved at the next Credentialing Committee meeting and kept in the Credentialing Department. If a tape recorder is used or notes taken, such tape or notes will be discarded or recycled immediately after the minutes are approved, unless specifically directed by the Medical Director.

24 Altering Conditions of Practitioner Participation and Appeal Rights

Please refer to the Corrective Action Plan and Judicial Review Hearing Plan.

25 Member Communication

As delegated, all physician directories and materials disseminated to members will be reviewed at the time of submission to ensure that the information provided regarding practitioner's education, training, certification, and designated specialty is consistent with the information gathered during the credentialing process.

Chapter II Healthcare Delivery Organizations

1 Definition

A Healthcare Delivery Organization (HDO) is an organization delivering health care services in the State of Arizona that is subject to review by the Arizona Department of Health Services (ADHS) and the Centers for Medicare and Medicaid (CMS).

2 Purpose

To ensure Healthcare Delivery Organizations meet established standards of participation.

3 Scope of Authorization and Action

HDOs covered under the Credentialing Plan include, but are not limited to, the following:

- Hospitals
- Behavioral Health Organizations - Mental health and substance abuse services to inpatient, residential and ambulatory settings
- Comprehensive Outpatient Rehabilitation Facilities
- Federally Qualified Health Center (FQHC)
- Free-standing Surgical Centers
- Home Health Agencies
- Hospice
- Laboratories
- Outpatient Diabetes Self-Management Training
- Outpatient Physical and Speech Therapy Centers
- Portable X-Ray Suppliers
- Renal Dialysis Facilities
- Rural Health Clinics (RHC)
- Skilled Nursing Facilities (SNF) and Nursing Homes
- Urgent Care Centers
- Telemedicine Providers
- Durable Medical Equipment Entities

HDOs not requiring credentialing under the AZPC Credentialing Plan are freestanding facilities where practitioners practice and/or provide care exclusively for members directed to the facility. These HDOs include, but are not limited to, the following:

- Mammography Centers
- Ambulatory Behavioral Healthcare Facilities
- Psychiatric and Addiction Disorder Clinics

4 Policy

Healthcare Delivery Organizations that fall within the Scope of Authority and Action will undergo initial HDO credentialing and be reviewed again at recredentialing every three (3) years (36 months) (with the exception of Urgent Care facilities, which are recredentialed every 2 years) thereafter, to ensure that the provider continues to be in good standing with federal and state regulatory bodies and reviewed and approved by an accrediting body.

5 Eligibility Criteria

A qualifying HDO must meet the following eligibility criteria. If at any time it is determined that the HDO does not meet criteria, the Credentialing Department will notify the HDO of its lack of qualifications and terminate the credentialing process. The HDO may not provide care to enrollees until a final decision is rendered from the Credentialing Committee.

State Licensure (facility/business)
Valid, current licensure issued by the State of Arizona.

National Provider Identifier (NPI)
Valid, current NPI

Accreditation and Onsite Quality Assessment
At the time of application, an HDO must meet these criteria by either one of the following:

- Current accreditation by an approved accrediting body or
- A current onsite quality assessment (conducted by AZPC)
- A ADHS or CMS site survey

Professional Malpractice Insurance
Current professional malpractice insurance with minimum coverage of:

- Hospitals: $3,000,000 per occurrence, $10,000,000 aggregate
- Others: $1,000,000 per occurrence, $3,000,000 aggregate

Liability coverage must be provided by a recognized financially viable carrier. If the HDO does not have malpractice insurance within the limits, it must be discussed at the committee and the decision must be documented in the committee minutes

General Liability Insurance
Current general liability insurance with minimum coverage of $1,000,000 per occurrence and $3,000,000 aggregate is required. Liability coverage must be provided by a recognized financially viable carrier. *If the HDO does not have malpractice insurance within the limits, it must be discussed at the committee and the decision must be documented in the committee minutes*

Sanctions
Absence of past or present sanctions by regulatory agencies, including Medicare sanctions.

** This requirement may be waived if evidence exists that the HDO is not currently sanctioned or prevented by a regulatory agency from participating in a federal or state sponsored program.*

- Compliance with federal requirements prohibiting employment or contracts with individuals excluded from participation under Medicare
- Compliance with federal, state and local requirements for handicap access as well as the standards required by the 1992 Federal American Disabilities Act

6 Credentialing Application

Acceptable applications include Hospital Participation Application or Ancillary Facility Application.

Applicant Attestation - Verification Time Limit - 180 calendar days

The authorized signature on the acceptable applications and any relevant information may not be older than 180 calendar days at the time of the Credentialing Committee's action. If the signed attestation exceeds 180 calendar days before review and action by the Credentialing Committee, the HDO will have the opportunity to update it. The HDO will be sent a copy of the completed application with the new attestation form requesting to update the application and attest that the information on the application is correct and complete. The HDO will not be required to complete another application. The attestation will address:

- History of sanctions, limitations on scope of practice or loss of licensure
- History of Medicare sanctions or restrictions
- History of disciplinary action or loss of accreditation
- Compliance with federal requirements prohibiting employment or contracts with individuals excluded from participation under Medicare
- Compliance with state, federal and local requirements for handicap access as well as the standards required by the 1992 Federal American Disabilities Act
- Correctness and completeness of application

Supporting Documentation

The following items may be requested in support of the application, as applicable:

- Copy of valid, current licensure issued by the State of Arizona
- Copy of valid, current accreditation certificate. If not accredited, copy of ADHS or CMS site review
- Copy of valid, current professional and general liability insurance face sheet that includes coverage limits and expiration date
- Copy of Medicare Certification (if applicable)

7 Initial Credentialing Procedure

Upon receipt of an application by the Credentialing Department, the application will be reviewed for completeness. The signed attestation and any relevant information must be no more than 30 days old to allow adequate processing time. Faxed, digital, electronic, scanned or photocopied signatures are

acceptable. Signature stamps are not acceptable. An incomplete application will be returned to the applicant.

7.1 Verifications

State Licensure (facility/business, PSV not required)
Valid, current licensure issued by the State of Arizona

NPI (verification time limit - 180 calendar days, PSV)
Valid NPI of type 2 (Organization) issued by National Plan and Provider Enumeration System (NPPES) will be verified via NPPES website.

Accreditation and Onsite Quality Assessment (PSV not required)
At the time of application, a HDO must meet this criterion by either one of the following:

- Current accreditation by an approved accrediting body
- A ADHS or CMS site survey (the survey date may not be greater than 3 years at the time of credentialing)
- A current onsite quality assessment (conducted by AZPC using the ICE Organizational Provider/Facility Site Review Tool & Corrective Action Plan for HDOs)

Acceptable Regulatory and Accrediting Bodies include:

A. Hospitals/Acute Care Facilities
   - The Joint Commission
   - Healthcare Facilities Accreditation Program (HFAP) Accrediting Program approved by the American Osteopathic Association (AOA)
   - Det Norske Veritas National Integrated Accreditation for Healthcare Organization (DNV)
   - Center for Improvement in Healthcare Quality

B. Behavioral Health Organizations
   - The Joint Commission
   - Commission on Accreditation of Rehabilitation Facilities (CARF)
   - Healthcare Facilities Accreditation Program (HFAP) Accrediting Program approved by the American Osteopathic Association (AOA)

C. Comprehensive Outpatient Rehab Facilities
   - The Joint Commission
   - Continuing Care Association Commission (CCAC)
   - The Commission on Accreditation of Rehabilitation Facilities (CARF)

D. Free Standing Surgical Centers, including stand-alone abortion clinics and multi-specialty outpatient surgical centers
   - Accreditation Association for Ambulatory Health Care (AAAHC)
   - American Association for Accreditation for Ambulatory Surgery Facilities (AAAASF)
   - The Joint Commission

- Healthcare Facilities Accreditation Program (HFAP) Accrediting Program approved by the American Osteopathic Association (AOA)Certified to participate in the Medicare program under Title XVIII (42 U.S.C. Section 1395 et seq.) of the Federal Social Security Act via a certificate or letter from Medicare.

E. Home Health Agencies
   - The Joint Commission
   - Accreditation Association for Ambulatory Health Care (AAAHC)
   - Community Health Accreditation Program (CHAP)
   - Accreditation Commission for Health Care, Inc. (ACHC)

F. Hospice
   - The Joint Commission
   - Community Health Accreditation Program (CHAP)

G. Laboratories
   - Applicable CLIA certificate or waiver
   - College of American Pathologists, Lab Accreditation Program
   - Commission on Office Laboratory Accreditation (COLA)

H. Outpatient Diabetes Self-Management Training Providers
   - American Association of Diabetes Educators (AADE)
   - Indian Health Service (IHS)

I. Portable X-Ray Supplier
   - Federal Drug Administration (FDA) Certification

J. Skilled Nursing Facilities
   - The Joint Commission
   - Continuing Care Association Commission (CCAC)
   - Commission on Accreditation of Rehabilitation Facilities (CARF)

Facilities not accredited or surveyed by the ADHS or CMS, will require an assessment performed by the Quality Improvement Department using the ICE Organizational Provider/Facility Site Review Tool & Corrective Action Plan for HDOs. The assessment may be varied according to the HDO type, size and complexity HDO and includes verification that all practitioners are credentialed. Interviews may be conducted with, but not limited to, senior management, chiefs of major services, key personnel in nursing, quality management or utilization management.

Professional and General Liability Insurance (PSV not required)
The insurance is verified by a copy of the HDO's current professional and general liability insurance face sheet, which includes effective dates and amounts of coverage as defined in the Eligibility Criteria Section.

Medicare Certification (If applicable, PSV not required)
A copy of Medicare Certification is required for Federally Qualified Health Centers, Outpatient Physical Therapy and Speech Pathology Providers, Outpatient Diabetics Self-Management Training Providers, Renal Dialysis Facilities, and Rural Health Clinics.

Office of Inspector General (OIG) (verification time limit - 180 calendar days, PSV)
Confirmation that the HDO is not listed on the Office of Inspector General website.

System for Award Management (SAM) (verification time limit - 180 calendar days, PSV)
Confirmation that the HDO is not listed on the Excluded Parties Lists System using the System for Award Management (SAM) website.

CMS Preclusion List (Verification Time Limit - 180 calendar days, PSV)
Confirmation that the practitioner is not listed on the CMS Preclusion List website.

8 Recredentialing Criteria

A formal recredentialing process is required every three (3) years with the process being completed within the month of the recredentialing date. There is no grace period beyond the 36-month allotted time period to re-verify information that may have changed over time. The three-year cycle begins with the date of the initial credentialing decision; and thereafter, three years from the recredentialing decision.

Exceptions
If AZPC cannot recredential a HDO within the 36-month time frame, AZPC must document the reason for the delay in the HDO's file. If a HDO is given administrative termination for reasons beyond AZPC's control (e.g., the HDO failed to provide complete credentialing information), and is then reinstated within 30 calendar days, AZPC may recredential the HDO as long as it provides documentation that the HDO was termed for reasons beyond its control and was recredentialed and reinstated within 30 calendar days of termination. AZPC must initially recredential the HDO if reinstatement is more than 30 calendar days after termination.

9 Recredentialing Application

The acceptable application is the Ancillary Facility application.

Applicant Attestation - Verification Time Limit - 180 calendar days
The recredentialing application includes a current and signed attestation by the applicant and addresses the following:

- History of sanctions and limitations on scope of practice or loss of licensure
- History of Medicare/ sanctions or restrictions
- History of disciplinary action or loss of accreditation
- Compliance with federal requirements prohibiting employment or contracts with individuals excluded from participation under Medicare
- Compliance with federal, state and local requirements for handicap access as well as the standards required by the 1992 Federal American Disabilities Act
- Correctness and completeness of application

Supporting Documentation

The following items may be requested in support of the application, as applicable:

- Copy of valid, current licensure issued by the State of Arizona
- Copy of valid, current accreditation certificate. If not accredited, copy of ADHS or CMS site review
- Copy of valid, current professional and general liability insurance face sheet that includes coverage limits and expiration date
- Copy of Medicare Certification (if applicable)

10 Recredentialing Procedure

A tickler file in the form of a checklist, spreadsheet or computer-generated report alerts credentialing staff of HDOs due for recredentialing. One hundred eighty days prior to expiration of the three-year (36-month) cycle, the HDO is sent a recredentialing application. The 36-month cycle begins with the date of the initial credentialing decision and is counted to the month, not the day.

If the application is not returned within 30 days, HDO will be contacted by a credentialing staff member to verify receipt of the application and request that the application is returned within 15 days. If the application is not returned within 15 days, assistance from Provider Relations and Contracting will be requested to obtain the recredentialing application. If the recredentialing application is not returned 90 days prior to the expiration of the three-year cycle, HDO will be notified via certified mail of intent to terminate.

Upon receipt of an application by the Credentialing Department, the recredentialing application will be reviewed for completeness. The signed attestation by the applicant should be no more than 30 days old to allow for adequate processing time. Faxed, digital, electronic, scanned or photocopied signatures are acceptable. Signature stamps are not acceptable. An incomplete recredentialing application will be returned to the applicant.

10.1 Verification

- State licensure (PSV not required)
- NPI (verification time limit - 180 calendar days, PSV)
- Accreditation and Onsite Quality Assessment (PSV not required)
- Professional and General Liability Insurance (PSV not required)
- Medicare Certification (If applicable, PSV not required)
- Office of Inspector General (OIG) (Verification Time Limit - 180 calendar days, PSV)
- System for Award Management (SAM) (Verification Time Limit - 180 calendar days, PSV)
- CMS Preclusion List (Verification Time Limit – 180 calendar days, PSV)

10.2 Performance Monitoring

Information derived from the practice experience of all HDOs is incorporated into the recredentialing process and reviewed by the Credentialing Committee. At a minimum, confidential member complaint data, information from quality improvement activities, utilization management performance data, and

member satisfaction data will be used to assess professional performance, judgment and clinical competence and will be used in the recredentialing decision process.

11 Credentialing Committee Review and Action

Completed HDO credentialing files are presented to the Credentialing Committee for review within 180 days in which the data gathered was verified. Possible action by the committee includes approval, denial and recommendation for improvement, monitoring, disciplinary action or request for further information.

A Medical Director designated by the Credentialing Committee has the authority to review and sign off on all clean files which have met AZPC's credentialing or recredentialing criteria. The date the file is signed by the Medical Director is the date that will be considered the "Committee Review Date". These files do not have to be reviewed by the Credentialing Committee to be approved.

12 Communication of Committee Action

The HDO is notified of the Credentialing Committee decision in writing. A copy of the letter will be kept in the HDO credentialing file. Documentation of adverse decisions will be kept in the file.

Chapter III Judicial Review and Appeals Rights Process

1 General

Arizona Priority Care (AZPC) may grant or deny a Professional Services Agreement to any practitioner with or without cause. AZPC may also terminate, suspend or limit any such Agreement with or without cause, subject only to the specific terms of such Agreement.

- When AZPC changes the terms of a practitioner agreement **without cause**, the affected practitioner **will not** be entitled to a hearing or review under this Judicial Review Hearing Plan.
- When AZPC changes the terms of a practitioner agreement **with cause**, the affected practitioner **will** be entitled to any hearing or review under this Judicial Review Hearing Plan.

When AZPC concludes in writing to deny, suspend, limit or terminate a Professional Service Agreement based on a medical disciplinary cause or reason, the affected practitioner will be entitled to request a hearing to appeal the decision.

For the purpose of this Judicial Review Hearing Plan, the term "medical disciplinary cause or reason" will refer to an aspect of a practitioner's competence or professional conduct, which is reasonably likely to be detrimental to patient safety or to the delivery of patient care. The term "staff privileges" will refer to any arrangement under which a practitioner is allowed to practice or provide care for patients in a health facility.

2 Purpose

To provide intra-professional resolution of matters bearing on professional conduct or competency of any practitioner defined by the Scope of Authorization and Action.

3 Scope of Authorization and Action

Practitioners covered under the Judicial Review Hearing ("Plan") include MDs, DOs, DDSs, DPMs, DCs and NPs. Allied health practitioners and non-physician behavioral health practitioners are not entitled to either information review or hearing rights pursuant to the Judicial Review Hearing Plan.

4 Policy

Where AZPC concludes in writing that its decision to deny, suspend, limit or terminate any Professional Services Agreement based on a medical disciplinary cause or reason, the affected practitioner will be entitled to request a hearing (appeal) under this Judicial Review Hearing Plan.

5 Delegation of Decision-Making Authority

The HPN Executive Committee delegates decision-making authority to the Credentialing Committee of Arizona Priority Care. The Credentialing Committee sub-delegates the judicial review hearing procedure to the Peer Review Committee/Quality Improvement Committee.

6 Annual Review

The AZPC Credentialing Committee will annually review, revise as necessary, and approve the Judicial Review Hearing Plan.

7 Grounds for a Hearing

Any one or more of the following actions or recommended actions will constitute grounds for a formal hearing:

- A practitioner's application for staff privileges is denied or rejected for a medical disciplinary cause or reason.
- A practitioner's staff privileges are revoked, terminated, or not renewed for a medical disciplinary cause or reason.
- Restrictions are imposed on staff privileges for a cumulative total of 30 days or more in any 12-month period for a medical disciplinary cause or reason.
- The imposition of summary suspension of staff privileges for a medical disciplinary cause or reason, if the summary suspension stays in effect for a period in excess of fourteen (14) days.

8 Hearing Procedure

8.1 Notice of Action or Proposed Action

Whenever there are grounds for a hearing and such action or proposed action is specifically stated to be for a medical disciplinary cause or reason, the practitioner will be given written notice of the proposed action and of the practitioner's right to request a hearing under the Judicial Review Hearing Plan (Appeal Rights).

The notice will include:

- Written notification indicating that a professional review action has been brought against the practitioner, including reasons for the action and a summary of the appeal rights and process (Judicial Review Hearing Plan). This written notification maybe a certified letter to a provider.
- That the action, if adopted, must be reported to the Arizona Medical Board and/or the National Practitioner Data Bank under 45 Code of Federal Regulations, Part 60.
- That the practitioner has the right to appeal the action and request a hearing.
- That the practitioner must request the hearing within 30 days of receipt of the notice and the request must be in writing to the AZPC Medical Director.
- That the practitioner may be represented by an attorney or another person of the practitioner’s choice.

- That a Hearing Officer or a panel of individuals will be appointed by AZPC to review the appeal.
- That the practitioner will be provided written notification of the appeal decision that contains the specific reasons for the decision.
- That the decision of the Judicial Hearing Committee may be more or less stringent and/or restrictive than the proposed corrective action.
- That both the action and decision must be reported to the Arizona Medical Board and the National Practitioner Data Bank under 45 Code of Federal Regulations, Part 60 and the health plans.

8.2 Practitioner Right to Appeal and Request for a Hearing

There is an appeal process for instances in which AZPC chooses to alter the conditions of the practitioner's participation based on issues of quality of care and/or service. The practitioner will be provided their appeal rights (via letter, email, fax or portal) and s/he has 30 days following the date of receipt of a notice of an adverse action to submit a written request for a hearing to the Medical Director. If the practitioner does not request a hearing within the timeframe and in the manner described, the practitioner will be deemed to have accepted the recommendation, decision, or action involved and it may be adopted as the final action.

8.3 Time and Place

Upon receipt of the practitioner's written request for a hearing, AZPC will promptly schedule and arrange for the hearing. The practitioner will be notified of the time, place, and date of the hearing. The date of commencement of the hearing will not be less than 30 days and not more than 60 days from receipt of the request for the hearing.

8.4 Notice of Charges and Witnesses

A notice of the charge(s) will be sent to the practitioner, either along with the notice of the hearing or separately, specifying the acts or omissions with which the practitioner is being charged. This supplemental notice will provide a list of the patient records, if any, which are to be discussed at the hearing only if the information has not been supplied previously.

Upon the request of either party, each party, at least 10 days prior to the hearing, will furnish to the other a written list of names and addresses of individuals, reasonably known or anticipated, who will give testimony or evidence in support of that party at the hearing. The witness list will be amended when additional witnesses are identified. Failure to comply with this requirement is good cause to postpone the hearing.

8.5 Judicial Hearing Committee

The Medical Director will appoint a Judicial Hearing Committee consisting of at least three participating AZPC practitioners who are eligible for voting rights on medical interpretation and peer review activities and have the requisite expertise to ensure an efficacious and fair hearing. The majority of members of the Hearing Panel will be peers of the affected physician. The Medical Director will chair the Judicial Hearing Committee and handle all pre-hearing matters. The hearing panel members will be

impartial, will not have actively participated in the formal consideration of the matter at any previous level (i.e., acted as accuser, investigator, fact finder or initial decision-maker in the same matter), will not be in direct economic competition with the affected practitioner, and will stand to gain no direct financial benefit from the outcome of the hearing.

8.6 Hearing Officer

AZPC will appoint a Hearing Officer to attend the hearing. The Hearing Officer will be an attorney at law who is qualified to preside over a formal professional peer review hearing. He/she will not be bias for or against the practitioner, will gain no financial benefit from the outcome, and must not act as a prosecuting officer or an advocate for any party. The Hearing Officer may participate in deliberations and act as a legal advisor to the Judicial Hearing Committee but will not be entitled to vote.

8.7 Presiding Officer

The Presiding Officer at the hearing will be the Hearing Officer as described above. The Presiding Officer will act to assure that all participants in the hearing have a reasonable opportunity to be heard and to present all relevant oral and documentary evidence in an efficient and expeditious manner. The Presiding Officer will assure proper decorum is maintained; and if either party is not proceeding as described, the Presiding Officer may take such discretionary action as seems warranted by the circumstances. The Presiding Officer will be entitled to determine the order of or procedure for, presenting evidence and argument during the hearing and will have the discretion, in accordance with the Judicial Review Hearing Plan provisions, to do the following:

- Grant continuances
- Rule on disputed discovery requests
- Decide when evidence may or may not be introduced
- Rule on challenges to hearing committee members
- Rule on challenges to him/her serving as the Hearing Officer
- Rule on questions raised prior to or during the hearing pertaining to matters of law, procedure or the admissibility of evidence
- Exercise discretion in formulating additional procedures not consistent with these hearing policies and procedures that are deemed reasonably necessary to affect an expeditious and efficient fair hearing

8.8 Pre-Hearing Procedure

It will be the duty of AZPC and the affected practitioner to exercise reasonable diligence in notifying the Presiding Officer of any pending or anticipated procedural irregularity as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters can be made expeditiously. Objection to any such pre-hearing decisions shall be raised at the hearing and, when so raised, reflected on the record.

8.9 Discovery

Rights of Discovery and Copying - The affected practitioner may inspect and copy (at his/her own expense) any documentary information relevant to the charges that AZPC has in its possession or under its control. AZPC or its representative may inspect and copy (at its expense) any documentary information relevant to the charges that the affected practitioner has in his/her possession or under his/her control. The right of inspection and copying does not create or imply an obligation to modify or create documents in order to satisfy a request for information. Requests for discovery must be fulfilled as soon as practicable. Failure to comply with reasonable discovery requests at least 30 days prior to the hearing will be good cause for a continuance of the hearing.

Limits on Discovery - The Presiding Officer, upon the request of either side, may impose safeguards including, but not limited to, denial of discovery request on any of the following grounds:

- The information refers solely to individually identifiable practitioners other than the affected practitioner.
- The safeguard is warranted to protect peer review.
- The safeguard is warranted to protect justice.

Discovery Disputes - In ruling on discovery disputes, the factors that may be considered include:

- Whether the information sought may be introduced to support or defend the charges.
- Whether the information is "exculpatory" in that it would dispute or cause doubt upon the charges or "inculpatory" in that it would prove or help support the charges and/or recommendations.
- The burden on the party of producing the requested information.
- What other discovery requests the party has previously made.

8.10 Pre-Hearing Document Exchange

At the request of either party, the parties must exchange all documents that will be introduced at the hearing. The documents will be made available at least thirty (30) days prior to the hearing. Failure to comply with this rule is good cause for the Presiding Officer to grant a continuance. Repeated failure to comply is good cause for the Presiding Officer to limit introduction of any documents not provided to the other side in a timely manner.

8.11 Representation

Both AZPC and the practitioner have the right to be represented by an attorney or other representative; however, in no case may an attorney represent AZPC if the practitioner is not otherwise represented. The foregoing will not deprive either party of their right to legal counsel for the purpose of preparing for the hearing.

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8.12 Failure to Appear

Failure without good cause of a practitioner to appear and proceed at the hearing will be deemed to constitute voluntary acceptance of the recommendation or action involved, and it will become the final action of AZPC.

8.13 Postponements and Extensions

Postponements and extensions of time beyond the times expressly permitted in the Judicial Review Hearing Plan may be requested by any affected person and will be permitted by the Presiding Officer on a showing of good cause. The Presiding Officer will ensure that hearing proceedings are conducted in a reasonably expeditious manner under the circumstances.

8.14 Record of the Hearing

The Judicial Hearing Committee will maintain a record of the hearing by using a Certified Transcription Reporter to record the hearing or tape record the proceedings. The practitioner will be entitled to receive a copy of the transcript or recording upon paying reasonable costs for preparing the record. The Presiding Officer may, but is not required to, order that oral evidence be taken only on an oath administered by a person entitled to notarize documents in the State of Arizona or by affirmation under penalty or perjury to the Presiding Officer that the testimony that he/she is about to give is true and correct.

8.15 Rights of Parties

Both parties have the following hearing rights to:

- Ask the Judicial Hearing Committee members and/or the Presiding Officer questions that are directly related to determining whether they meet the qualifications set forth in this Judicial Review Hearing Plan and to challenge such members or the Presiding Officer.
- Call and examine witnesses.
- Introduce relevant documents and other evidence.
- Receive all information made available to the Judicial Hearing Committee.
- Cross-examine or otherwise attempt to impeach any witness who testified orally or on any matter relevant to the issues.
- Rebut any evidence.
- Submit a written statement at the close of the hearing, which the Judicial Hearing Committee may request be filed following the conclusion of the presentation of oral testimony.

Additional Hearing Rights:

- The practitioner may be called by AZPC and examined, as if under cross-examination.
- The Judicial Hearing Committee may interrogate witnesses or call additional witnesses if deemed appropriate.

8.16 Rules of Evidence

Rules of law relating to the examination of witnesses and presentation of evidence in courts of law will not apply in any hearing conducted hereunder. Any relevant evidence, including hearsay, will be admitted by the Presiding Officer if it is the sort of evidence that responsible persons are accustomed to rely upon in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

If the charges and recommendations are actions imposed by the Credentialing Committee as a result of a decision based on the initial credentialing process or recredentialing process, AZPC may object to the introduction of any evidence that was requested of an applicant, but not provided, during the applicable process. The Presiding Officer will sustain such objections unless the applicant can prove that the information could not have been produced previously in the exercise of reasonable diligence.

9 Basis of Decision

The decision of the Judicial Hearing Committee will be based on the evidence produced at the hearing and any written statements submitted to the Judicial Hearing Committee. If the Judicial Hearing Committee should find the charges to be true, it will recommend such form of discipline as it finds warranted. The recommended discipline may confirm or be more or less harsh and/or restrictive than that recommended by AZPC.

10 Burden of Going Forward and Burden of Proof

Initial Burden – In all cases, AZPC will have the burden of initially presenting evidence to support the charges and its recommendation. Thereafter, the burden differs depending upon whether the practitioner is applying for a Professional Services Agreement or already has a Professional Services Agreement.

Denial of Initial Agreement – At any hearing involving denial of an initial Professional Services Agreement, the practitioner has the burden of proving by a preponderance of the evidence (i.e., more likely than not) that he/she is qualified for an Agreement in accordance with the eligibility standards of AZPC. The practitioner must produce information that allows for an adequate evaluation and resolution of any reasonable doubts concerning his/her current qualifications, subject to AZPC's right to object to the production of certain evidence pursuant to the Rules of Evidence listed above.

Termination of Agreement or Suspension, Reduction or Limitation of Privileges – In all other cases involving a practitioner who already has a Professional Service Agreement, AZPC will have the burden of proving by a preponderance of evidence that the action or recommendation is reasonable and warranted. The term "reasonable and warranted" means within the range of reasonable and warranted alternatives available and not necessarily that the action is the only measure or the best measure that could be taken in the opinion of the Judicial Hearing Committee.

11 Adjournment and Conclusion

The Presiding Officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. The hearing will be conducted within a reasonable amount of time. The Presiding Officer may set guidelines for introduction of evidence to achieve a timely conclusion. Upon conclusion of the presentation of oral and written evidence and argument, the hearing will be closed. The Judicial Hearing Committee will thereupon, outside of the presence of the parties, conduct its deliberations and render a decision and an accompanying report. Final adjournment will not occur until the Judicial Hearing Committee has completed its deliberations.

12 Decision

The Judicial Hearing Committee will render a decision within 30 days of the final adjournment of the hearing. A written report that contains findings of facts and conclusions that articulate the connection between the evidence produced at the hearing and the decision rendered will accompany the decision. The report will include sufficient detail to enable the affected practitioner and AZPC to determine the basis for the decision of the Judicial Hearing Committee on each matter contained in the Notice of Charges. The decision and report will be delivered to the affected practitioner and AZPC within 15 days of the committee decision. The decision of the Judicial Hearing Committee is the final decision.

13 Reporting

All required reports will be filed in accordance with Arizona State requirements when there are adverse decisions resulting from the peer review process.

14 Privileges and Immunities

All activities conducted pursuant to this Judicial Review Hearing Plan are in reliance on the privileges and immunities afforded by the Federal Health Care Quality Improvement Act and applicable laws in the State of Arizona.

Chapter IV Corrective Action Plan

1 Purpose

To provide a fair and efficient means to identify, investigate, and resolve problems arising from the conduct of a practitioner who falls within the Scope of Authorization and Action that may adversely affect patient care or the operations of Arizona Priority Care (referred to herein as "AZPC")

2 Scope of Authorization and Action

Practitioners covered under the Corrective Action Plan include MDs, DOs, DDSs, DPMs, DC, NPs and PAs who care for AZPC members. Allied health practitioners and non-physician behavioral health practitioners are not entitled to either information review or hearing rights pursuant to the Corrective Action Plan.

3 Policy

An investigation or corrective action may be requested when a practitioner engages in or exhibits acts, statements, demeanor, or professional conduct, either within or outside of the workplace, reasonably likely to be detrimental to patient safety or the delivery of quality patient care and reasonably likely to result in the imposition of sanctions by any governmental authority (federal, state or local).

4 Delegation of Decision-Making Authority

The Arizona Priority Care Executive Committee delegates decision-making authority to the Credentialing Committee of AZPC. The Credentialing Committee sub-delegates the corrective action procedure to the Peer Review Committee/Quality Improvement Committee.

5 Annual Review

The AZPC Quality Improvement Committee will annually review, revise as necessary and approve the Corrective Action Plan.

6 Corrective Action Procedure

6.1 Initiation

A proposed investigation or corrective action will be initiated by AZPC on its own initiative or by a written request, which identifies the specific activities or conduct that are alleged to constitute grounds for proposing an investigation or corrective action.

6.2 Preliminary Review

Prior to investigation, AZPC may, but is not obligated to, conduct a preliminary review of any allegation made in support of a request for an investigation or corrective action.

6.3 Practitioner Interview

The practitioner, although not required, may be granted an interview. If any interview is granted, the practitioner will be informed of the general circumstances and may present any relevant information. Discussions and findings resulting from the interview will be documented. Interviews will not be constituted or deemed an "investigation" or "hearing". Following the interview, AZPC may choose to proceed with the investigative process.

6.4 Investigation

The Medical Director will identify members to participate in a committee or ad hoc committee to investigate the alleged issue or problem. The Chairperson of the assigned committee will prepare a written report as soon as feasible. No investigative process will be constituted or deemed a "hearing", as described in the Judicial Review Hearing Plan. The investigative process may be terminated at any time to proceed with action as described in Section 6.5.

6.5 Action

At the conclusion of the investigative process, but not more than 60 days after receipt of the proposed investigation or corrective action, unless deferred pursuant to this plan, such action may include, without limitation, the following:

- No corrective action
- Rejection or modification of the proposed corrective action
- Letter of admonition, reprimand, or warning
- Terms of probation or individual requirements of consultation
- Limitation of privileges
- Suspension of privileges until completion of specific conditions or requirements
- Revocation of privileges
- Other action appropriate to the facts which prompted the investigation

Nothing set forth herein shall prohibit AZPC from implementing summary suspension at any time in the exercise of its discretion.

6.6 Deferral of Action

If additional time is needed to complete the investigation process, the action may be deferred. Action must be taken within the deferred time specified, or if no time specified, within 30 days of the deferral.

6.7 Procedural Rights

Any action that constitutes grounds for a hearing will entitle the practitioner to procedural rights as provided in the Judicial Review Hearing Plan. When this is the case, the practitioner will be notified in writing of the adverse action and his/her rights to request a hearing.

7 Summary Suspension

7.1 Initiation

Whenever a practitioner's conduct requires immediate action to reduce a substantial likelihood of imminent impairment of health or safety of any patient, prospective patient, employee or other person, the Medical Director and at least two other voting Credentialing Committee members shall have the authority to summarily suspend all or any portion of the practitioner's privileges.

Such summary suspension becomes effective immediately upon imposition and the person responsible will promptly give verbal or written notice of the suspension to the practitioner. The notice of suspension will constitute a request for corrective action and the corrective action procedure will be followed. Any patients whose treatment by the practitioner is terminated by the summary suspension will be assigned to another practitioner to be determined by the Medical Director.

7.2 Procedural Rights

Unless the summary suspension is terminated, it will remain in effect during the pendency and completion of the corrective action process of the hearing process. The practitioner will not be entitled to procedural rights as provided in the Judicial Review Hearing Plan until final action, and then only if the final action taken constitutes grounds for a hearing as set forth in the Judicial Review Hearing Plan.

8 Automatic Suspension

8.1 Professional Licensure

Revocation or Expiration: Automatic and immediate termination of privileges will occur upon revocation or expiration of a practitioner's license by a licensing authority, which will remain in effect for at least the term of revocation or expiration.

Restriction: Automatic and immediate limitations and restrictions will be placed upon a practitioner's privileges within the scope of limitations or restrictions by a licensing authority, which will remain in effect for at least the term of revocation or expiration.

Suspension: Automatic and immediate suspension of privileges will occur upon suspension of a practitioner's licensure by a licensing authority, which will remain in effect for at least the term of suspension.

Probation: A practitioner's privileges will be modified as necessary to comply with the terms and conditions of probation by a licensing authority. Modifications will remain in effect at least for the term of probation.

8.2 Drug Enforcement Administration Certificate

Revocation or Expiration: Automatic and immediate revocation of a practitioner's right to prescribe medication will occur upon revocation of a practitioner's DEA certification, which will remain in effect for at least the term of revocation or expiration.

Restriction: Automatic and immediate suspension of a practitioner's right to prescribe medication will occur upon suspension of a practitioner's DEA certificate, which will remain in effect at least for the term of suspension.

Probation: A practitioner's right to prescribe medications covered by the DEA certification will be modified as necessary to comply with the terms and conditions of probation. Modifications will remain in effect at least for the term of probation.

8.3 Failure to Satisfy Special Appearance Requirements

A practitioner who fails, without good cause, to appear and to satisfy the requirements of a special appearance of which that practitioner had notice, will automatically be suspended from exercising all or such portion of his/her privileges which may be suspended until he/she appears and satisfies the requirement of that special appearance.

8.4 Further Investigation and Action

As soon as possible after automatic suspension, consideration of facts surrounding the automatic suspension will be reviewed and considered, which could initiate an investigation and/or further corrective action.

8.5 Procedural Rights

The practitioner will not be entitled to hearing rights until further action, if any, and then only if that further action constitutes grounds for a hearing as provided in the Judicial Review Hearing Plan.

9 Reinstatement of Privileges

A practitioner who has been subject to suspension or restriction will not, by the passage of time, or the curing of the event which gave rise to the automatic suspension, be automatically reinstated to his/her status and/or privileges. Instead, the practitioner must submit a written request for reinstatement along with a completed application. The practitioner will bare the burden of producing clear and convincing evidence of his/her qualifications.

10 Reporting Requirements

When there are adverse decisions resulting from the peer review process, reports will be filed in accordance with the Arizona Medical Board by AZPC Quality Improvement Department. The practitioner will be advised of the report and its contents. All reports made shall be deemed confidential. Reports will be made in writing to following entities:

10.1 Arizona Medical Board

Denied Privileges: A practitioner's application is denied or rejected for medical disciplinary cause or reason.

Timeframe: A report will be filed within 15 days after conclusion of all proceedings.

Termination or Revoked Privileges: A practitioner's status is terminated or revoked for medical disciplinary cause or reason, fraud, or in the case of imminent harm to the member.

Timeframe: A report will be filed within 15 days after conclusion of all proceedings.

Restrictions on Privileges: Restrictions on privileges are imposed or voluntarily accepted for a cumulative total of 30 days or more for any 12-month period for a medical disciplinary cause or reason.

Timeframe: A report will be filed within 15 days after conclusion of all proceedings.

Resignation or Leave of Absence: The practitioner resigns or takes a leave of absence following notice of an impending investigation based on information indicating a medical disciplinary cause or reason.

Timeframe: A report will be filed within 15 days after the effective date.

Summary Suspension: A summary suspension remains in effect in excess of 14 days.

Timeframe: A report will be filed within 15 days following the imposition of summary suspension, if the summary suspension remains in effect for a period in excess of 14 days.

Accusation of Misconduct: A physician or other healing arts licensee who is accused by a patient, in writing, of sexual abuse or sexual misconduct. Sexual misconduct is defined as "inappropriate contact or communication of a sexual nature."

Timeframe: A report will be filed within fifteen (15) days of receipt of a written accusation to the appropriate state licensing agency. No hearing rights will be afforded prior to filing this report. A follow-up report may be filed when the investigation is completed.

Supplemental Report: A supplemental report will be made within 30 days following the date the practitioner is deemed to have satisfied any terms, conditions, or sanctions imposed as disciplinary action.

Diversion Report: A report will be filed with the Arizona Medical Board when formal investigation of a practitioner's ability to practice safely due to a disabling mental or physical condition may pose a threat to patient care.

Timeframe: A diversion report will be filed within 15 days of initiating the formal investigation. No hearing rights will be afforded prior to filing this report. A follow-up report will be filed when the investigation is completed.

10.2 National Practitioner Data Bank

Professional Competence or Conduct: An action based on a practitioner's professional competence or conduct that adversely affects or could affect the health or welfare of a patient and remains in effect for more than 30 days.

Timeframe: A NPDB report will be filed within 15 days from the date the adverse action was imposed.

Surrender or Restriction of Authority While Under Investigation: Acceptance of the practitioner's surrender or restriction of authority to provide care to patients while under investigation for possible professional incompetence, improper professional conduct, or in return for not conducting an investigation or professional review action.

Timeframe: A NPDB report will be filed within 15 days from the date the adverse action was imposed or authority to provide care to patients is voluntarily surrendered.

Supplemental Report: If necessary, a report will be filed to make revisions to a previously reported adverse action.

10.3 Healthcare Integrity and Protection Data Bank

Civil Judgments: Civil judgments related to the delivery of a health care item or service (except those resulting from medical malpractice).

Timeframe:

- *Within 30 days from the date the final adverse action was taken.*
- *Within 30 days of the date AZPC became aware of the final adverse action.*
- *By the close of the next monthly reporting cycle.*

Adjudicated Actions or Decisions: Adjudicated actions or decisions related to delivery of a health care item or service taken against a health care practitioner (excluding clinical privileging actions). Other adjudicated actions or decisions that are formal or official final actions that:

- Are taken against a health care practitioner by a federal or state government agency or a health plan.
- Include the existence of a due process mechanism.
- Are based on acts or omissions that affect or could affect the delivery or payment of a health care item or service.

Timeframe:

- *Within 30 days from the date the final adverse action was taken.*
- *Within 30 days of the date AZPC became aware of the final adverse action.*
- *By the close of the next monthly reporting cycle.*

11 Health Plan Notification

Health plans will be notified of final adverse actions.

Timeframe: Within 15 days of the final adverse action.

Chapter V Attachments

A. Credentialing Confidentiality and Affirmative Statement

B. Verification Sources

Attachment A - Credentialing Confidentiality and Affirmative Statement

Arizona Priority Care™

One Goal. One Priority. Your Healthcare.

CONFIDENTIALITY AGREEMENT
and
AFFIRMATIVE STATEMENT

Confidentiality Agreement

As a member of the Arizona Priority Care Credentialing Committee, I am charged with the duties of credentialing physicians/providers rendering care to Arizona Priority Care members. I recognize that confidentiality is vital. Therefore, I agree to respect and maintain the confidentiality in connection with all Credentialing activities. I understand that by signing this agreement, I am binding myself by contract to maintain such confidentiality. I agree that I will not make any voluntary disclosure of such confidential information except to persons authorized to receive it.

Furthermore, in participating on the Credentialing Committee, I am relying on every other member of the committee and every other individual involved in credentialing committee affairs to similarly preserve the confidentiality of these activities. I understand that they have entered or will enter, into agreements identical to this one and I am a beneficiary of such agreements. I enter into this agreement for the express benefit of the other members of the Credentialing Committee and other individuals involved in credentialing affairs.

This obligation of strictest confidence shall survive the termination of my membership of the Credentialing Committee.

Lastly, Credentialing/Re-credentialing actions are not based solely on a practitioner's race, ethnic/national identity, gender, age, sexual orientation or the types of procedure (e.g. abortions) or types of patients (e.g. Medicaid) to which the practitioner provides services. This will not preclude actions regarding practitioners who meet certain demographic or specialty needs, i.e., to meet cultural needs of members.

Affirmative Statement

Arizona Priority Care in no way rewards or incentivizes, either financially or otherwise, Practitioners, Utilization Management reviewers, Care Managers, Physician Advisers, or other individuals involved in conducting utilization review, for issuing denials of coverage or service, or inappropriately restricting care.

Signed:_____ Dated: _____

Attachment B - Verification Sources

SERVICE	SITE NAME, ADDRESS AND PHONE NUMBERS	WEBSITE
OIG - List of Excluded Individuals and Entities (LEIE) excluded from Federal Health Care Programs: Medicare/Medicaid sanction & exclusions	HHS Officer of Inspector General	www.oig.hhs.gov
Individuals and Organizations debarred from participating in government contracts or receiving government benefits or financial assistance	SAM (System for Award Management) formerly known as Excluded Parties List System (EPLS)	https://www.sam.gov/portal/SAM/?portal=#1#1
Medicare Opt-Out	Centers for Medicare & Medicaid Services (CMS)	https://data.cms.gov/Medicare:Enrollment/Opt-Out-Affidavits/7yuw-754z/data
Exclusions and reinstatements from Arizona State Health Program	AHCCCS (Arizona Health Care Cost Containment System	https://azahcccs.gov/Fraud/Providers/