

Health Network Solutions, Inc. (HNS)

Credentialing Plan

*The HNS Credentialing Program is part of the HNS Quality Assurance program. The HNS Credentialing Program is consistent with NCQA, URAC and state and federal requirements. HNS does not delegate or outsource any of the services we provide; all services are provided by the management and staff of HNS and/or members of the HNS Board of Directors.

Health Network Solutions, Inc.

Credentialing Plan: Policies and Procedures

Subject: Credentialing and Recredentialing
Effective Date: April 1, 1997
Reviewed and/or revised: December 20, 2010
Modified: August 26, 2011

Introduction

The HNS Credentialing Program, Plan and Policies are part of the HNS Quality Improvement/ Quality Assurance Program.

Participation begins when the credentialing process has been completed and when the provider's Practitioner's Participation Agreement to provide professional services has been accepted and executed by HNS, and the provider is notified in writing by HNS of the decision of the Credentialing Committee.

Participation with the HNS network is a privilege and is not a right and all applications and requests for participation shall be evaluated in accordance with the policy herein. Gender, race, religion, creed, ethnic/national origin, sexual orientation or the type of procedure provided or the type of patient to whom service was rendered or any other criteria lacking professional justification shall not be considered in determining qualifications for participation with HNS.

The Practitioner's Participation Agreement is effective when properly signed and executed by both the applicant and an appropriate agent of HNS, the credentialing process has been completed and HNS' Credentialing Committee has granted the privileges.

This policy is reviewed and updated or changed as deemed necessary by HNS and the Credentialing Plan and Policies are reviewed in their entirety at least once annually.

Purpose

Credentialing is the initial process through which HNS collects reviews and verifies specific criteria and prerequisites in order to approve or deny a provider's eligibility for requested privileges with HNS.

Recredentialing is the process through which HNS reviews the provider's performance through multiple sources: updates and reverification of all pertinent provider information, and examination and verification of the clinical competence of the participating provider.

Recredentialing shall be conducted at least every three (3) years. More frequent recredentialing may occur at the sole discretion of HNS.

Non-Discriminatory Process

The credentialing and recredentialing of HNS providers is conducted in a non-discriminatory manner. Individual characteristic issues of race, gender, sexual orientation, religion, color, disability, age, ethnic/national origin, type of procedure or type of patient, (such as Medicare, etc.), status as a disabled veteran are not considered during the credentialing or recredentialing process. HNS has established procedural guidelines to insure that the approval or denial of files was done so in compliance with nondiscriminatory guidelines. Our commitment to this requirement begins with the selection criteria of our Credentialing Committee membership. Our Credentialing Committee is composed of a diverse group of individuals that understand their responsibility to ensure that all providers meet established criteria and that a provider's inclusion or exclusion is not in violation of the discrimination policy.

HNS had taken the following measures to prevent nondiscrimination in the provider selection or continued participation process:

- A. Prior to each credentialing meeting, the Credentialing Director sends to all committee members a list of all provider's who are scheduled to be credentialed or recredentialed at the upcoming meeting. Each committee member reviews the list of providers and must complete an attestation statement indicating that he has reviewed the list, and attests that he has no financial or business interests in any provider and/or knows of any reason that he may be unable to make decisions about those providers in a non-discriminatory manner.
- B. Should any committee member have any business or financial interests of any kind with any provider shown on the list , or otherwise indicates he may not be able to make decisions about provider(s) shown on the list in a non-discriminatory manner, that committee member will not be allowed to participate in the review of that provider's file. These signed attestation statements are maintained in a secured electronic environment.
- C. The credentialing chairman or chairmen assures this lack of discrimination by attesting, at each credentialing meeting, that no discussion of gender, sexual orientation, race, color, religion, disability, age, national origin, status as disabled veteran or personal or financial considerations occurs during the monthly Credentialing Committee meetings and also attests to the same in the minutes for each meeting.
- D. In order to ensure fair and unbiased decision making during the credentialing, recredentialing and quality review processes, any committee member who has direct or indirect financial interest in any provider's file to be reviewed will not be allowed to participate in the review of the credentialing file, and will be excused from any portion of the meeting that directly or indirectly involves the review of that provider.

E. Additionally, HNS' Credentialing Committee members are required to sign the "HNS Confidentiality Statement". The "HNS Confidentiality Statement" includes a non-discrimination credentialing and recredentialing clause and has been signed by all HNS Credentialing Committee members. HNS' Credentialing Committee members are required to re-attest by signing the "HNS Confidentiality Statement" on an annual basis. These statements are on file for review during onsite audits of our credentialing files.

F. HNS conducts quarterly audits of randomly selected credentialing and recredentialing files (both approved and denied) to monitor provider participation decisions and ensure that decisions were conducted in a non-discriminatory manner. This audit will include a review of a minimum of six files each quarter. Additionally, HNS will review any provider complaints related to any allegations of discrimination and will address such allegations in the monthly Credentialing Committee meeting. (Modified 6/23/11 and again on 7/8/11)

G. At this time HNS credentials only chiropractors and we will not discriminate against any provider who acts within the scope of his or her chiropractic license, under applicable state law, solely on the basis of that license. (Modified August 26, 2011)

H. HNS will not discriminate against providers with high risk populations. (Modified August 26, 2011)

Minutes

Contemporaneous minutes shall be taken of the Credentialing Committee meetings and maintained in a confidential manner.

Changes to Credentialing Plan

Only substantive and/or material changes to the HNS Credentialing Plan require approval of the HNS Credentialing Committee. Changes made for clarification to existing language to not require approval of the HNS Credentialing Committee. (Added September 30th 2010)

Scope

The scope of HNS' credentialing/reccredentialing process shall at a minimum include chiropractors (DC's). All practitioners participating in HNS will be subject to the credentialing/reccredentialing process defined in this policy.

Target geoaccess guidelines

There are 100 counties in North Carolina. 52 counties have more than 50,000 citizens and HNS defines these counties as *urban areas*. Our access guidelines are targeted to offer coverage of a minimum of two chiropractors within a 15 mile radius in urban areas in N.C. There are 48 counties with less than 50,000 citizens and HNS defines these counties as *rural Areas* and our geoaccess guidelines are targeted to provide a minimum of one provider within a 30 mile radius.

Note: Two Chiropractors in a 15 mile radius = 2 chiropractors every 706.5 square miles ((15 x 15) x 3.14). The total square miles of NC Urban area is 29,880, indicating that HNS should have at least 43 chiropractors in urban areas. There are 48 counties with less than 50,000 citizens and HNS defines these counties as Rural Areas. 1 Chiropractor within a 30 mile radius = 1 chiropractor every 2,826 square miles ((30 x 30) x 3.14). The total square miles of NC Rural area is 18,831, indicating that HNS should have a minimum of 7 chiropractors in urban areas. (Modified for clarification August, 2010)

HNS reviews geoaccess target guidelines and compares to our network provider access, and continues our recruiting efforts to better serve members in rural areas and to further enhance our network.

Provision of Health Care Services.

- A. Network chiropractors must provide to beneficiaries those authorized health care services in accordance with accepted chiropractic standards in the community
- B. Network chiropractors must provide Beneficiaries with access to appropriate chiropractic services at all times, twenty-four (24) hours a day, seven (7) days a week including holidays, including arranging for coverage by another Participant when unavailable or establishing alternate coverage arrangements approved in advance by HNS.

(Modified August 10, 2010 for clarification)

Provider Rights and Responsibilities

- A. The provider applicant shall produce all information required by the application, or requested by HNS, in addition to the application, for proper evaluation of his/her malpractice status, status of state license, competence, character, ethics, and other qualifications, and for resolving any doubts about such qualifications and professional integrity for both credentialing and recredentialing purposes.
- B. All providers shall have the following rights:
 - To review information submitted to support their application
 - To correct erroneous information
 - To be informed, upon request, of the status of their application

HNS will promptly respond to a provider's request for information regarding the status of their application. Responses to such requests may be given either via telephone or written notification sent via US Postal Service. Best efforts will be made to provide responses within 72 hours of the request. When responding to such requests, HNS will provide the physician with:

- The date the application was received at HNS

- Actual status of the application on the date the inquiry was received, and would include either “application is in process”, or “application has been returned as incomplete and HNS requires additional information”
- If the application is in process, HNS will also inform the provider of the tentative date that his/her application will be presented to the credentialing committee for final determination. (HNS Credentialing Plan modified to include this language on 05/17/08)

C. HNS recognizes a provider’s right to review the information submitted or obtained in support of their credentialing/recredentialing applications to the extent permitted by law. HNS will notify a provider by telephone or letter of any information obtained during the HNS’ credentialing or recredentialing process that varies substantially from the information provided to HNS by the Provider. Should a provider desire, he/she has 10 days from the receipt of this notice to request a review of the file, at a mutually agreed upon time. The provider may not remove the file from HNS premises. The provider may submit additional or correct information, in the form of original or notarized documents (if appropriate) to HNS’ credentialing staff within 10 days from the receipt of the original notice or, should the provider choose to review the file, within 10 days of that date. HNS’ Credentialing Committee will consider any additional information submitted by the provider.

D. HNS has the responsibility to effectively implement corporate policy and to credential and recredential providers consistent with NCQA, URAC credentialing standards, state and federal laws, and those policies established by HNS’ Credentialing Committee and the contracted payors that HNS represents.

Peer Review

A. Approval or denial of an applicant’s completed request for credentialing or recredentialing is the decision of HNS’ Credentialing Committee. The HNS Credentialing Committee is comprised of full-time practicing chiropractors. In order to ensure fair and unbiased decision making during the credentialing, recredentialing and quality review processes, any committee member who has direct or indirect financial interest in any provider reviewed is required to remove himself from participation in the review of that provider’s file. If the Credentialing Committee Chairperson or person must be excused from the review of a provider’s file then the Chairman will appoint a designee to sign the file.

The Credentialing Committee shall consider all information collected and verified during the credentialing process to evaluate compliance with the requirements stated in this policy, prior to making recommendations regarding the credentialing or recredentialing of providers.

B. Evidence of the committee’s review of a provider’s credentials shall be documented in meeting minutes. The Credentialing Committee Chairperson or designee shall sign and date the decisions of the committee in the meeting minutes. Signature may be in the form of a signature stamp by one of the chairpersons.

- C. The Credentialing Committee shall meet as frequently as necessary, but at a minimum 12 times a year for the purpose of conducting credentialing activities and to ensure the compliance of the information verification dates being less than 180 days from the date of the Credentialing Committee action. Providers whose contracts are terminated without cause, or who terminate their contract without unresolved quality issues, automatically and without action by the Credentialing Committee will no longer be credentialed or participate with HNS as of the effective date of the termination.

Denial of Application

Upon request, providers who do not meet HNS credentialing criteria, with the approval of HNS Credentialing Committee Chairperson, may withdraw from the credentialing process. This withdrawal may occur without action by the Credentialing Committee and requires no report to the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank (NPDB-HIPDB). If the applicant chooses to withdraw his/her application, HNS shall notify the provider in writing of the withdrawal action. Applicants who are rejected for non-quality issues, such as failure to recredential, lack of need for additional providers by our network, or graduation from a non CCE chiropractic college shall not require action by the Credentialing Committee and require no report to the NPDB-HIPDB.

Notification

Upon determination of provider status (suspension, withdrawal, final approval, or denial) a letter of notification shall be sent to the provider.

If HNS elects not to include an applicant in its network for a reason that does not require review of the application, best efforts will be used to notify the applicant within 60 days after the receipt of the application.

Confidentiality

- A. The credential files will be held in strict confidence. HNS has developed and implemented procedures to promote the confidential maintenance of, and dissemination of credentialing and recredentialing files and Credentialing Committee minutes, or portions therein, to authorized persons.
- B. If a provider is applying for participation in the HNS network and is joining an existing HNS provider practice, and the applicant does not meet credentialing criteria, HNS may, at its discretion, inform the participating provider that the applicant does not meet credentialing criteria. However, other than to state that the applicant does not meet credentialing criteria, no confidential information as to the reasons for the denial will be provided to the participating provider.

- C. With respect to terminations for cause, the Committee reserves the right to release broad information relating to such terminations if such actions are deemed necessary to explain and or defend the actions and/or reputation of the Committee or the organization. By way of example, if a provider is terminated for cause for violations of the terms of his Practitioner's Participation Agreement, HNS, reserves the right to release that information. However, the specific terms and or HSN and/or HNS payor policies related to the termination will not be disclosed.
- D. Procedures to assure confidentiality include, but shall not be limited to:
 - 1. Confidentiality agreements are signed by all credentialing personnel.
 - 2. Confidentiality statements are signed by all visiting delegated partners during audits.
 - 3. Paper files are maintained in locked areas and credentialing meeting minutes are filed electronically and are password protected.
 - 4. Computerized files are password protected with limited employee access.
- E. Quality files that contain peer review information are protected from disclosure. To prevent this information from being open to discovery, such quality files shall be kept separate and secured from provider credentialing files.
- F. The Credentialing Committee when making recredentialing decisions shall consider both the credentialing and the quality file.
- G. Credentialing files will not be produced for outside parties without prior approval from HNS' Corporate Law Counsel.

Statutory and Regulatory Compliance

HNS shall identify statutory and regulatory issues related to credentialing and recredentialing not otherwise covered by the corporate policy and shall develop and implement procedures for compliance with the pertinent issues.

Authority and Responsibility

- A. HNS shall, in a timely fashion, seek to collect and verify the credentials documents, licensure and other qualifications and other evidence that may be required and/or submitted and shall maintain paper and electronic database files to provide HNS with sufficient supporting documentation to prepare files for committee review.
- B. The HNS Board of Directors appoints the Credentialing Committee Chairmen and the Chairmen appoint all physician members of the committee.
- C. The HNS Board of Directors appoints the administrative representative(s).
- D. The Chairmen reviews and presents each applicant's summary credentials file to the Credentialing Committee and comments on areas that need discussion.

- E. The Credentialing Committee has authorized the Medical Director(s) who serve as Chairmen, to make final determination on those applications with no adverse issues or issues that in the judgment of the Medical Director(s) that do not require Credentialing Committee review. The Medical Director(s) will indicate his review and approval of the file by initialing and dating the file. (Modified for clarification 6/23/11). If the Credentialing Committee Chairperson or person must be excused from the review of a provider's file due to a conflict of interest, then the Chairman will appoint a designee to sign the file.

- F. The Credentialing Committee reviews the applications of providers who do not or no longer meet HNS' established criteria for participation. The Credentialing Committee reviews summarized provider information including the education, qualifications, experience, malpractice history and all adverse actions for all applicants. The Committee will make the final determination regarding the provider's requested initial participation or continued participation with HNS. (Modified for clarification 6/23/11)

- G. The Medical Director and/or the Credentialing Committee if the Medical Director deems it necessary, reviews all quality issues as required by the HNS ongoing quality monitoring policy.
 - 1. All quality complaints are logged in the provider's quality file and the Medical Director reviews all quality issues every month.

 - 2. If such quality issues present in the provider's initial credentialing or recredentialing file, the Medical Director reviews the issue prior to the Credentialing Committee meeting. Evidence of this review is via his initials (and the date of his review) in the applicant's file. If the Medical Director believes that the quality issue needs further review by the Credentialing Committee, the committee minutes for that month will reflect such discussion and the outcome or follow up required. If there are no quality issues to address, the committee meeting minutes will so state.

 - 3. If a quality issue is brought to the attention of HNS via an outside source, such as member complaints, payor complaints, or any other outside source, this information is logged into the provider's quality file and is given to the Medical Director for review prior to the next Credentialing Committee meeting. If the Medical Director, after review of the issue, determines that no action is required by HNS, the Medical Director so attests by initialing and dating the relevant documents in the file. If the Medical Director believes that the quality issue needs further review by the Credentialing Committee, the committee minutes for that month will reflect such discussion and the outcome or follow up required. If there are no quality issues to address, the committee meeting minutes will so state.

4. The HNS Recredentialing Verification Checklist, “Provider Quality Complaints” section indicates whether the provider has had any quality complaints.
 - If the provider has had no quality issues, HNS enters zero (0) here to reflect this.
 - If the provider has an issue deemed a “quality issue” by one of the HSN Medical Directors, HNS enters the appropriate number to reflect the number of quality issues since the provider’s last credentialing date. If this form reflects that a provider has had a quality issue, the committee minutes will reflect the discussion of this issue or the appropriate pages of the file will show review by the Medical Director indicating that this issue did not need additional review or action by the committee. (Modified for clarification 05/17/08). However, not all issues discussed during the Credentialing Committee are considered quality issues and if not, will not be reflected on the Verification Checklist.

H. The Committee Chairmen, who serve as HNS’ Medical Director(s) have the final authority and ultimate responsibility in all credentialing and quality assurance issues.

1. The Credentialing Committee approves or denies each application.
 - a) Evidence of the Credentialing Committee’s review will be documented in the meeting minutes.
2. The Credentialing Committee meets at a minimum twelve times a year. At the discretion of the Chairperson, meetings may be held more or less frequently to meet the needs of the organization.
 - a) A quorum is 50% of those present at each meeting. HNS Credentialing Committee meetings are conducted either in person or by teleconferencing. (Modified for clarification 6/23/11.)
 - b) Members serve two-year terms that automatically renew every two years however; the Committee Chairmen can excuse members from serving and/or appoint members, as needed or as necessary.
 - c) Only physician members have voting privileges.
 - d) By order of the Board of Directors, the acting Credentialing Committee Chairmen/Medical Directors are Michael Binder, DC and Steve Binder, DC. The HNS Board of Directors and Drs Steve and Michael Binder have appointed the following members to serve on the current committee: Matthew Schmid, D.C., Larry Grosman, D.C., Dr. Rick Jackson, Dr. Dick Armstrong, Dr. Bob Stroud (alternate), and Dr. Ira Rubin (alternate).
 - e) Administrative Member(s) appointed by the HNS Board of Directors are Parker Binder.

- f) The Credentialing committee must also include one participating provider, who has no role in the management of the company. That provider, effective 03/29/06, is Dr. Fred Nelson.

H- A. Provisional Credentialing

Pursuant to 2009 NC H 1297

§ 58-3-230. Uniform provider credentialing.

(a) An insurer that provides a health benefit plan and that credentials providers for its networks shall maintain a process to assess and verify the qualifications of a licensed health care practitioner within 60 days of receipt of a completed provider credentialing application form approved by the Commissioner. If the insurer has not approved or denied the provider credentialing application form within 60 days of receipt of the completed application, upon receipt of a written request from the applicant and within five business days of its receipt, the insurer shall issue a temporary credential to the applicant if the applicant has a valid North Carolina professional or occupational license to provide the health care services to which the credential would apply. The insurer shall not issue a temporary credential if the applicant has reported on the application a history of medical malpractice claims, a history of substance abuse or mental health issues, or a history of Medical Board disciplinary action. The temporary credential shall be effective upon issuance and shall remain in effect until the provider's credentialing application is approved or denied by the insurer. When a health care practitioner joins a practice that is under contract with an insurer to participate in a health benefit plan, the effective date of the health care practitioner's participation in the health benefit plan network shall be the date the insurer approves the practitioner's credentialing application.

Temporary credentials of a provider are subject to the approval of the Medical Director.

I. Quality - HNS Provider Practice Sites (NCQA -CR6)

Exterior Requirements:

- This office should provide adequate parking at all times for patients and staff.
- The parking lot and building should accommodate the handicapped.
- The grounds should be well lit in the early morning and evening to accommodate patients, especially during the winter months.
- The property should be policed for trash and debris.
- The landscape should be kept neat and weed free.
- The front entrance should be kept clean (especially the door).
- The entrance to the office should be identified.
- Provisions should be made for proper snow/ice removal.

Interior Requirements:

Waiting Area(s):

- The waiting area(s) should provide comfortable seating.

- There should be a minimum of three (3) chairs for each physician.
- The seating should allow easy access for those with orthopedic difficulties.
- Magazines and literature should be current and in good condition.
- Educational and recreational material should be provided.
- The waiting area(s) should be kept neat and clean at all times.
- The appearance (decor) of the waiting area(s) should be reviewed for pleasantness and wear.

Examination/Treatment Room(s):

- There should be an adequate number of examination/treatment rooms to satisfy the current patient volume and projected growth in the upcoming six-month period.
- There should be adequate equipment in each room to satisfy the current patient volume and projected growth in the upcoming six month period.
- The equipment should be reviewed for wear on a regular basis.
- The rooms should be reviewed for pleasantness.
- The door width(s) should accommodate the handicapped.
- Private area(s) should be provided in which the patient can discuss personal health conditions with the physician/staff.

Business Office:

- The business office should be kept neat.
- The business office should be kept clean.
- The business office should be adequately equipped to handle all administrative tasks necessary for current practice volume and projected growth in the upcoming six-month period.
- Private area(s) should be provided in which the patient can discuss personal, financial issues with the physician/staff.

Restroom(s):

- The Restroom(s) should be clean.
- The Restroom(s) should accommodate the handicapped, including grab bar.
- The Restroom(s) should be well stocked.

Safety (physical aspect):

- All exits should be clearly marked with "emergency exit signs".
- A fire extinguisher should be maintained with current inspection sticker.
- A first aide kit should be at the site and restocked as supplies are used, including smelling salts.
- An OSHA approved biohazard spill kit should be kept at the site and restocked as supplies are used.
- A pregnancy reminder sign should be prominently displayed in the x-ray room.
- A radiation caution sign should be prominently displayed in the x-ray room.
- X-ray chemical tanks should be properly marked with hazardous material warning labels.
- Staff should have access to an extra rest room key in the event of an emergency.

Scheduling

Patients should be able to get an appointment on the same day if the situation appears urgent.

Patients should be able to be seen within 14 days if not urgent.

- All patients should be seen (on average) within 15 minutes of their scheduled appointment time.
- All personnel answering the telephone should be aware of how much time to allow for procedures.
- All personnel answering the telephone should be aware of insurance plan participation of your office, as well as requirements for pre-authorizations to properly direct the patient prior to the appointment time.
- All personnel answering the telephone should be able to give accurate directions to the office.
- There should be a procedure in place for following up on missed appointments.
- There should be a procedure in place for handling emergency walk-ins.
- The office hours should be clearly posted in each HNS office.
- Telephone answering machine/voice mail should provide clear instructions regarding after hours chiropractic care.

Patient Records

- HNS provider offices must have a secure/confidential filing system that assures the confidentiality of patient health records.
- Only authorized employees of the provider should have access to patient health information.
- The office should conduct an annual review to assure compliance with appropriate HIPAA regulations.
- All patient records must be stored so that they are easily retrievable.
- HNS has developed documentation, coding and billing requirements for all providers based on industry standards, the ACA Documentation Recommendations and in conjunction with our contracted payors. Providers are expected to strictly adhere to these requirements. (See HNS Payor Policies)
- There should be an individual record for each family member (family members must not be combined in the same file jacket).
- Records should be maintained in chronological or reverse chronological order.

Complaints and Monitoring

- All complaints will be logged into our HNS Practitioner Site Complaint Spreadsheet which is part of the provider's quality file.
- All complaints will be investigated by HNS either via a direct phone call to the provider, written notification of the complaint or a site visit. Resolution of such complaints will be noted on the HNS Practitioner Site Complaint Spreadsheet.

- HNS will require that site visits be conducted whenever we receive two (2) or more practitioner site complaints regarding the same provider, within a calendar year.
- Only employees of HNS who have a minimum of five (5) years experience in credentialing will conduct site visits. The HNS Credentialing Director and the Chief Executive Officer are the only individuals currently qualified to conduct site visits. Both of these individuals have been educated and appropriately trained regarding NCQA/URAC credentialing standards.
- A Site Visit Survey Form will be completed within 72 hours of each site visit and filed in the provider's confidential file.
- If a site visit is necessary, then the provider will be required to submit a written action plan outlining how his/her plan to correct the deficiencies. This action plan for correction must include a time line and deficiencies must be corrected within six (6) month or less, depending on the type of complaint and the work required to correct the deficiencies. The written action plan will be reviewed by the Credentialing Committee and a follow up site visit for reassessment will be scheduled within six (6) months to assure correction of deficiencies. Providers who have not corrected such deficiencies within the six (6) month period will be terminated from the network.
- Each month, the HNS Credentialing Committee will monitor ALL complaints regarding practitioner sites via a review of the HNS Practitioner Site Complaint Spreadsheet. Evidence of this ongoing monitoring of Practitioner Site Complaints will be included in the monthly HNS Credentialing Committee meeting minutes.

Application

- A. In the credentialing process, a provider shall be required to complete the appropriate *Uniform Application to Participate as a Health Care Practitioner* application form.
- B. The application signature date, or approved attestation statement, shall not exceed 180 days from the date the file is presented for review to the HNS Credentialing Committee.
- C. The applicant shall be requested to complete all parts of the application, provide necessary explanation when applicable, or adequately explain any failure to do so. The applicant shall be instructed to place "not applicable" in all sections that are not applicable to the provider. The application requires original or faxed signature of the applicant. Signature stamps shall not be accepted on credentialing files but is acceptable on recredentialing files.

HNS' credentialing department shall make decisions about the completeness and acceptability of an application. Incomplete applications will be returned to the provider within 15 days with a request to complete missing components and/or provide missing documentation prior to resubmission to HNS and/or the provider will

be contacted by the HNS credentialing department staff, via phone or fax, to obtain additional needed information from the provider.

- D. Any information discovered during the verification process that is inconsistent with the information provided by the application will be communicated to the applicant for further explanation. Apparent deliberate submission of false information on the application shall constitute grounds for termination of the application process and the provider may be withdrawn from consideration for participation.
- E. The signed and dated application (both initial and recredentialing, unless otherwise stated) shall require detailed information concerning:
 - 1. Applicant's professional education. (The education element is not required on the recredentialing application.)
 - 2. A list of the applicant's work history since graduation from Chiropractic College, or the applicant may indicate on the application to refer to attached curriculum vitae (CV) for work history information. Written explanation shall be required for any gaps in work history greater than 90 days. (This element is not required to be on the recredentialing application.)
 - 3. Current state professional license number(s) and history of any loss or limitation of professional license and/or any felony conviction in any jurisdiction at any time prior to the date of the application.
 - 4. Current professional liability (malpractice) insurance coverage with limits of \$1 million per occurrence/ 3 million aggregate; and evidence of any actions, claims, suits alleging malpractice involving the applicant from his/her present and past professional liability (malpractice) insurance carrier that occurred at any time prior to date of the application.
 - 5. Reasons for any inability to perform essential functions of the position, with or without accommodations.
 - 6. Lack of present illegal drug use.
 - 7. A signed and dated Attestation Statement by the applicant regarding correctness and completeness of the application and consent for release of information to HNS.

Credentialing Fees

There is no credentialing fee to join the HNS network.

Credentialing Process

- A. Applicants for participation with HNS shall file with HNS, a completed, signed and dated appropriate *Uniform Application to Participate as a Health Care Practitioner* form.

- B. A good faith effort will be made by HNS to collect and verify the documents, and all other required documentation, and to notify the provider of the decision of the Credentialing Committee within 60 days of receipt of the completed application.
- C. The Credentialing Committee may deny an application on or before the 60 day period if all information needed to make a reasonable decision has not been obtained. Additionally, HNS reserves the right to “pend” such an application for an additional 60 days, to allow the committee time to obtain needed information, should the committee so choose. Should the Credentialing Committee pend an application, HNS will notify (in writing) the applicant of the pending status within 60 days of receipt of the original application.
1. An individual file shall be established on each provider.
 2. A file containing incomplete information will be returned to the provider within 15 days with notification of missing components and/or documents. A request will be made either via US mail or telephone, for the provider to resubmit a completed application to HNS.
 3. Receipt of a completed file shall be logged into a computerized spreadsheet showing date of receipt of the application. Files shall also be date stamped on at least the first page and Attestation Statement page.
 4. A record shall be established in the credentialing file with the completion of defined data elements. This record shall be in the form of a checklist.
 5. No verification shall be greater than 180 days old at the time a final decision is reached by the Credentialing Committee. This includes, but is not limited to, the original Attestation Statement signed by the applicant.
 6. Documentation of information shall include the initials of the individual who verified the information, the date of the verification, the name of the person supplying the information (if oral), and the source of the verification and expiration date of any information, if applicable. This documentation shall be maintained in the provider’s file.
 7. Provider files, which may contain any criteria deemed by HNS as warranting intensified Credentialing Committee review will be flagged on the committee meeting agenda (see Target Criteria for Denial in this policy).
- D. After all required information is collected and verified, provider files are presented to the Credentialing Committee for a determination as to the applicant’s participation with HNS.
1. Criteria for credentialing of providers shall include:
 - a. Current, unencumbered state license
 - b. NPDB (This is effective 2005, previously the malpractice carrier was queried rather than NPDB)
 - c. Chiropractic Information Network/Board Action and Disciplines (CIN-BAD) (Query search criteria is by provider’s name.)
 - d. NPDB-HIPDB, effective 02/01/09

- e. Two letters of recommendation from peers (cannot be from relative or partner) and must be on approved HNS form. (For NC providers only as of special meeting 05/15/08.)
- f. Must be in full time practice at one location for approximately 24 hours per week. These criteria may be waived if the provider is practicing in an underserved area and/or if there are extenuating circumstances supporting less than 24 hours per week deemed acceptable by the Credentialing Committee.

2. Additional criteria for approval shall include:

- The provider must maintain an office within the HNS service area.
- There is a need for HNS providers within the specific geographic area to accommodate HNS' business obligations with respect to geoaccess. If low or no billing activity, credentialed providers will not be allowed to remain in the network.
- Effective May 30th, 2006, if the applicant practices within a group practice, (reporting revenue under the same EIN with other chiropractors at his/her office) then all providers within the group practice are required to be credentialed with HNS or none of the providers in the group practice can participate with HNS.
(12/28/10 added for clarification) this requirement was added at the request of certain contracted payors to reduce confusion for beneficiaries who, when they seek care at a practice listed as an "in-network" provider's office, will reasonably believe that the providers at that practice are participating plan providers.
- If the provider has previously been a participating provider and during that time, failed to adhere to the terms of the HNS Practitioner's Participation Agreement and/or HNS and or HNS payor polices and/or, then the Credentialing Committee reserves the right to deny the application if it is in the best interests of HNS, our providers and our contracted payors.

- E. The Credentialing Committee recommends approval or denial of the applicant's participation with HNS.
- F. A letter is sent to each applicant notifying him/her of the action of the Credentialing Committee within 60 days of receipt of complete credentialing application and within 60 days of receipt of complete recredentialing application *unless the application is pended for additional information.*
- G. Providers have the right to review the information submitted in support of their credentialing application and have the right to correct erroneous information. Providers shall be notified of any discrepancy in information obtained from the

History	documented in the credentials file.	
4. Current State Professional License in state where practicing	State licensing board via direct request to licensing board website or office.	Yes
5. Completion of professional school as applicable to the profession For DC: Graduation from chiropractic college	On an annual basis, HNS obtains written verification from each state licensure board (NC, SC, and VA) whereby each board re-attests to their responsibility for primary source verification of the provider's education. Should HNS' network expand to require credentialing providers from states other than NC, SC or VA, primary source verification will be confirmed as the responsibility of that state. If the licensing board confirms primary source verification, no further query will be necessary. If the board does not query direct, direct college query will be performed. (Modified for clarification 6/23/11)	No
6. Current Malpractice Insurance	Certificate copy or declaration sheet stating dates of coverage and amounts of coverage.(If phone call is made to verify this, HNS will document name of person providing information, date called, and expiration date of policy and policy limits.	Yes
7. Request information from State Department for Professional Regulation (licensing boards) regarding any sanction activity (reviewed monthly)	CIN-BAD for Chiropractors – query by last name, not by state. (CHANGED 09/27/07).	Yes
8. Review Medicare and Medicaid sanction activity (reviewed monthly)	Medicare/Medicaid sanction	Yes

<p>9. Two letters of recommendations must be included with each new application and cannot be from a relative or partner. (Per special Credentialing Committee meeting on 05/15/08. Note: This is effective for N.C. providers only and effective for all applications sent after May 15, 2008. This policy is not retroactive.</p>	<p>section of CIN-BAD for chiropractors by last name (Changed 09/27/07)</p> <p>Must be on HNS approved form</p>	<p>No</p>
<p>10. Ongoing Quality Monitoring - review of any quality issues</p>	<p>Any quality issues will be reviewed by the Medical Director and/or the Credentialing Committee, if the Medical Director deems it necessary.</p>	<p>Yes</p>
<p>11. NPDB – HIPDB For additional malpractice, criminal and out-of-state history</p>	<p>(Already in the Credentialing Plan but added to this section for clarification on 05/17/08)</p>	<p>Yes</p>
<p>12. NPI verification</p>	<p>Effective 01/26/09, HNS also queries HIPDB for all credentialing and recredentialing files.</p> <p>Not required for credentialing, but effective May 11, 2010, HNS will verify Type 1 and Type 2 NPI numbers for each provider credentialed and will attach confirmation of this in the provider’s credentialing file</p>	<p>No</p>

Credentials File

- A. A credentials file shall be maintained for each provider included within the scope of the policy by HNS.

- B. Contents of HNS' file may be limited to those items received by HNS directly from the provider and the product of any further information received in the verification process performed by HNS.
- C. A summary checklist of the credentials verifications for use by the Credentialing Committee in making decisions shall be maintained in the file. The checklist shall include date of verification and initials of credentials staff receiving information. The profile shall document the following:
 - 1. Date entered into credentialing database
 - 2. Review of work history
 - 3. Malpractice claims history
 - 4. Medicare/Medicaid sanctions/exclusions
 - 5. Licensure Board actions/disciplines
 - 6. Graduation from professional school
 - 7. State licensure
- D. A completed, signed/dated initial application and signed/dated attestation statement/consent form must be present.
- E. The credentials file shall be maintained in a standardized format as determined by HNS.
- F. The credentialing file shall include written notification to the provider of adverse Credentialing Committee actions.
- G. The Practitioner's Participation Agreement (contract) shall be maintained in the credentials file.

Recredentialing Process

- A. Recredentialing is the process through which HNS reviews the provider's performance through multiple sources; updates and reverification of all pertinent provider information; examination of his/her clinical competence; and the participating provider's cooperation and compliance to HNS and payor policies.
- B. Recredentialing shall be conducted at least every three (3) years or sooner, at the discretion of HNS. Updates and verifications of the provider's credentials will be ongoing. HNS shall query CIN-BAD on a monthly basis for new board actions or Medicare/Medicaid sanctions activity. If a provider shows new activity on either report, the Credentialing Committee shall flag the provider's file for recredentialing review at the next available meeting.
- C. A recredentialing application is sent to each participating provider at least 30 days prior to the expiration of the provider's last credentialing date.

- D. HNS shall, in a timely fashion, seek to collect and verify licensure, malpractice insurance coverage, and all other required recredentialing documents.
- E. HNS shall have a procedure for coordinating provider performance appraisal information to include summary reports regarding utilization, quality issues and shall include patient and or payor complaints/satisfaction. This shall be in the form of HNS' Practice Performance Profile. This may include such quality issues, which will be reviewed by the Medical Director and/or presented to the Credentialing Committee for review. The minutes of each Credential Committee meeting will reflect either the discussion of such quality issues or the minutes will state that "there were no quality issues to discuss at this meeting" (Added for clarification on 05/18/08.)
- F. After all required information is collected and verified, the file is presented to the Credentialing Committee for a decision on the applicant's continued participation with HNS.
- G. A summary checklist of the recredentialing verifications for use by the Credentialing Committee in making decisions shall be maintained in the file. The checklist shall include date of verification and initials of credentials staff receiving information. The profile shall document the following:
 - 1. Date recredentialing due for completion
 - 2. Date recredentialing application sent and received
 - 3. Malpractice claims history
 - 4. Medicare/Medicaid sanctions/exclusions
 - 5. Licensure Board actions/disciplines
 - 6. State licensure
 - 7. Statement of number of quality issues for review, if any
 - 8. Provider files, which contain any criteria deemed by HNS as warranting intensified Credentialing Committee review, will be flagged on the committee meeting agenda. See Target Criteria for Denial in this policy.
- H. The Credentialing Committee may approve or deny the applicant's participation with HNS.
- I. The Credentialing Committee may choose not to approve a provider's continued participation in the HNS network if there is no longer a business or geoaccess need for that provider's continued participation in the network. If no billing activity, or low billing activity when compared to other providers in the same geographic area, credentialed providers will not be allowed to remain in the network.
- J. A letter is sent to each applicant notifying him/her of the recommendation of the Credentialing Committee.

Query and Sanction Activity

- A. Information on the practitioner is sought from the following organizations in an effort to identify possible sanctions or disciplinary actions:
 - 1. Chiropractic Information Network/Board Action and Disciplines (CIN-BAD)
 - 2. State Board of Chiropractic Examiners
 - 3. Medicare/Medicaid sanction report accessed through CIN-BAD
 - 4. National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank (NPDB-HIPDB)
- B. Evidence of the query requests upon initial and recredentialing shall be kept in the provider's credential/recredential file. Responses containing adverse information or quality information are kept in the provider's quality file.
- C. Each month HNS shall query CIN-BAD to review for any new board actions or Medicare/Medicaid sanctions for any of its participating providers.

Target Criteria for Denial / Termination

- A. HNS seeks to assure that providers are appropriately trained for the scope of the practice they will be providing to HNS contracted members (chiropractic).
- B. The Credentialing Committee meeting minutes will document discussion of a provider's training, when appropriate. There are times when a practitioner being credentialed or recredentialed by HNS will present, through query or application, less than optimal qualifications or practice history or other information that may suggest that it is not in the best interests of the organization to credential or recredential a provider. It is the intent of the Credentialing Committee to uniformly select quality physicians, which may result in a recommendation to the Committee Chairman to consider an exception to established guidelines.
- C. In general, the following issues will cause a failure to approve a credentialing or recredentialing file and/or may result in termination from the HNS network:
 - 1. Failure to complete an application after two repeated requests.
 - 2. Apparent deliberate falsification of an application.
 - 3. Conviction for acts of moral turpitude or actions against licenses for moral turpitude.
 - 4. Absence of evidence of initial proper professional training in programs approved by licensing agencies, or failure to receive required continuing education courses as mandated by state licensing agencies.
 - 5. Absence of a current unencumbered license to practice chiropractic.
 - 6. A non-satisfactory explanation or refusal to explain a lapse in work history.

7. Allowing malpractice insurance to lapse or be canceled for any reason, and/or malpractice coverage at less than the HNS minimum requirements. In such cases, HNS will consider a provider for participation in the network provided he/she obtains prior acts coverage for the period of time for which the 'claims made' policy was not in force. Such "prior acts" coverage would protect against any claims that may be brought since the termination of the claims made policy and the effective date of the new claims made policy. Such prior acts coverage must be in the minimum amounts required by HNS. Alternatively, after the statute of limitations expires that relate to the period of time when the claims-made policy was not in force, a provider would be considered for participation in the network, provided all other credentialing criteria are met.
8. Evidence of current untreated alcohol or drug addiction or hospitalization for psychiatric disturbance.
9. Any felony conviction. (Depending on the nature of the felony conviction, and if the conviction has resulted in incarceration and/or probation and the incarceration and/or probation period has been completed, and the completion of such periods is more than five (5) years from the date of the application, HNS may, after review and approval from contracted payors' credentialing and/or quality assurance committees, allow the provider to reapply for consideration for participation in the HNS network.)
10. Any violations of the terms of the HNS Practitioner's Participation Agreement and/or violations of contracted payor policies and/or violations of HNS policies and or violations of any policies or practice guides issued by the applicable Board of Chiropractic Examiners.
11. Malpractice claims history, which, after examination by the Credentialing Committee, indicates a propensity for malpractice, and/or are unusual for a provider in that particular specialty OR any malpractice claims history determined to be unacceptable by the Credentialing Committee.
12. Any combination of any malpractice claim(s) and restrictions or sanctions to the provider's state license, or quality issues, may, after review by the Credentialing Committee, result in failure to credential or recredential.
13. Violations of state or federal laws relating to false or fraudulent billing practices.
14. If the Credentialing Committee has reasonable grounds to believe that a provider is or has been engaged in felonious and/or fraudulent activity or engaged in conduct that may cast doubt on the professional integrity of the provider, which may potentially harm the reputation of the organization in the eyes of contracted payors or in the eyes of the public.
15. If the provider fails to comply with requests for information, either from HNS or a contracted payor, relating to any payor (and/or) HNS QI or UM program and/or relating to any investigation regarding suspicion of fraudulent activity, including inappropriate billing by the provider or any misconduct by the provider.
16. The Credentialing Committee reserves the right not to reconsider an applicant for participation with HNS if that provider was previously credentialed by HNS

- but subsequently terminated his/her contract with HNS, OR whose contract was terminated by HNS, whether for cause or without cause.
17. If a provider was previously credentialed and failed to notify HNS of a substantive change to his/her practice information, per the terms of the provider's Practitioner's Participation Agreement, section 3.3.
 18. If the provider is administratively non-compliant, such as persistent unremedied policy violations, member services issues (such as failure to follow HNS policies and/or HNS contracted payor policies). Termination for administrative non-compliance requires a written notice to the provider and does not require a report to the NPDB-HIPDB.
 19. Except in the event of serious accident, illness or injury or death, if a provider voluntarily leaves his/her practice without making appropriate arrangements for the continuation of chiropractic care for those patients actively under his/her care. (Based on Tenet VIII of the ACA Code of Ethics- Doctors of chiropractic have an obligation to the profession to endeavor to assure that their behavior does not give the appearance of professional impropriety. Any actions which may benefit the practitioner to the detriment of the profession must be avoided so as to not erode the public trust.)
 20. If the provider's utilization, coding, billing and/or documentation patterns are outside the HNS range of acceptance or are in violation of HNS or payor policies, and the provider, after receiving a written warning, does not comply with established policies and/or whose utilization is not within the HNS range of acceptance as directed by HNS or HNS contracted payors.
 21. Providers must provide services in an established office practice setting and cannot provide chiropractic services via a mobile unit.
 22. The Credentialing Committee may choose not to approve a provider's continued participation in the HNS network if there is no longer a business or geoaccess need for that provider's continued participation in the network. If no billing activity, or low billing activity when compared to other providers in the same geographic area, credentialed providers will not be allowed to remain in the network. (modified for clarification 082611)
 23. If the HNS determines that there is sufficient number of providers to meet HNS business obligations in a particular geographic area in which the provider is practicing, HNS reserves the right to deny that application for participation and/or to terminate that provider's existing participation agreement and/or not to renew the participation agreement. (modified for clarification 082611)
 24. HNS will not contract with providers excluded from participation in Federal health care programs (modified 08/26/11)

HNS reserves the right to immediately suspend the "participating" status of any provider for a period of up to 120 days to investigate concerns by a payor, by the applicable Board of Chiropractic Examiners, by HNS or any of its committees. The provider will be notified in writing of such a suspension via certified mail or other means that assures the appropriate notification by HNS to the provider. HNS will notify all contracted managed care organizations of any such suspensions. At the end of the suspension period of

120 days, the provider may be granted full participating provider status or may be terminated, either for cause or without cause. Full or partial credentialing or recredentialing of the provider may be required to reinstate the provider to full “participating provider” status.

D. If requested, the following issues will require review and response by the participating provider and review by the HNS Medical Director(s) and the HNS QI and/or UM Committee(s).

1. Any confirmed sanction against the license by the appropriate State Board of Examiners.
2. All CIN-BAD, NPDB-HIPDB reported claims.
3. Any confirmed Medicare or Medicaid sanction within the past three (3) years, which has not been fully remedied (Sanctions due to non payment of student loans do not always require written response by the provider and/or review by the HNS Medical Director and generally, will not necessarily result in denial of an application for participation or continued participation with HNS.)
4. Any and all malpractice claims history which, after examination by the Credentialing Committee, warrants review and/or indicates a propensity for malpractice, and/or are unusual for a provider in that particular specialty.
5. Any suspicion of fraudulent or felonious activity or any conduct which casts doubt on the professional integrity of the provider.
6. Any felony conviction.
7. Violations of terms of the HNS Practitioner’s Participation Agreement.

E. The Credentialing Committee shall also consider the following additional criteria upon recredentialing:

1. Unremedied member service issues.
2. Unremedied HNS policy and/or HNS contracted payor policy violations.
3. Persistent over utilization or underutilization as defined by HNS.
4. Inability to maintain a productive working relationship with HNS, defined as persistent failure to communicate, observe policies, or a demonstrated lack of cooperation with HNS representative and/or HNS contracted payors and/or HNS UM/QM program/committee implementation.
5. Timely physician response to a request for information pertaining to a payor complaint and/or suspected felonious and/or fraudulent activity (whether from a HNS contracted payor or by HNS), professional misconduct or quality or utilization management issue.
6. Failure to promptly respond to a member’s request for copies of his/her health care records.
7. Persistent shall be defined as one (1) or more written notification or two (2) documented faxed or telephone communications from HNS.
8. Non-renewal of HNS Practitioner’s Participation Agreement (contract).
9. Any violations of HNS Practitioner’s Participation Agreement.

10. The Credentialing Committee may choose not to approve a provider's continued participation in the HNS network if there is no longer a business or geoaccess need for that provider's continued participation in the network. If no billing activity, or low billing activity when compared to other providers in the same geographic area, credentialed providers will not be allowed to remain in the network.
11. If HNS determines that there is sufficient number of providers to meet HNS business obligations in a particular geographic area in which the provider is practicing, HNS reserves the right to deny that application for participation and/or to terminate that provider's existing participation agreement and/or not to renew the participation agreement.

HNS reserves the right not to renew any contract, upon no less than 30 days written notice prior to the expiration of the contract term OR upon no less than 30 days written notice prior to the actual scheduled recredentialing date, which is three (3) years from the date of the previous recredentialing of the provider. Non-renewal of a contract does not require reporting to CIN-BAD, NPDB-HIPDB.

Contract Termination

- A. Providers whose Practitioner's Participation Agreement is terminated by HNS *without cause, and without unresolved quality issues*, or providers who choose to terminate their existing participating provider contract *without unresolved quality issues*, automatically and without action by the Credentialing Committee, will no longer be credentialed or participate in HNS contracts as of the effective date of such termination (in accordance with the terms of the Practitioner's Participation Agreement) and such terminations shall not be reported to NPDB-HIPDB or CIN-BAD).

Only providers who are terminated *for cause or without cause*, due to non-administrative issue(s) will require Credentialing Committee action and their participation in the HNS network may be terminated immediately or may be terminated within 30 days of receipt of the written HNS notification of termination. All such terminations will be reported to CIN-BAD, NPDB-HIPDB, and if appropriate, to the appropriate State Board of Chiropractic Examiners. Such terminations will be reported within 30 days of termination. (Examples of a termination for cause: termination for action against or loss of state license, termination for continued lack of compliance to HNS and/or payor policies; termination for fraud, termination for continued utilization patterns outside the HNS range of acceptance.) When a reportable incident occurs, the Credentialing Director will send written notification, either by email or letter, and will file a report utilizing the reporting function of the NPDB-HIPDB databases.

(Modified for clarification 05/17/08.) (Modified for clarification 6/23/11)

- B. HNS may terminate a provider's participation in HNS for any failure to observe the policies or procedures established by HNS or its contracted payors, either for cause or without cause, in accordance with any agreement between the provider and HNS.

“Failure”, among other issues, may refer to failure of the provider to observe policies or procedures that continue *after written notice is given*, and/or failure to cooperate and/or respond timely to any request to the provider from HNS or payor, for information deemed necessary to investigate an allegation or suspicion of misconduct or fraud. Such a provider will no longer be credentialed or participate in HNS contracts as of the effective date of such termination.

- C. Failure to complete a recredentialing application after two repeated requests constitutes termination for cause. Requests may be via written notice or via telephone or facsimile. Notice of termination for failure to return the application shall be included with a second request for application completion and will be sent via certified mail or by commercial carrier and shall include the date of termination shall be included.
- D. Notice of termination, with our without cause, is sent to the provider by certified mail, return receipt requested or by commercial carrier, to assure receipt by provider, *provided HNS has a current address for the provider.*
- E. It is the responsibility of HNS to notify all contracted managed care organizations of the provider's termination date for removal from plan participation. Best efforts shall be made to notify each plan within 15 days of termination.
- F. Any provider returning to the network after termination *for any reason and for any length of time*, must be fully credentialed and approved by the HNS Credentialing Committee prior to attaining participation status with HSN.

Hearing and Appeal Process

(This section modified September 30, 2010)

With the exception below, any physician may submit an appeal to HNS for any adverse determination (suspension, termination, or denial for participation) decision in the credentialing or recredentialing process. Appeals must be in writing and are reviewed by the Credentialing Committee within the next 60 days.

Exception: HNS is not required to consider an appeal or schedule a hearing for providers whose participation has been denied due to felony convictions, OIG sanctions, actions by state licensing boards and/or who have allowed their malpractice insurance coverage to lapse and who do not immediately obtain prior acts coverage for the period of time that the claims-made coverage was not in force. Additionally, HNS is not required to consider an appeal or schedule a hearing for providers who were previously in the HNS network but failed to adhere to the terms of HNS Practitioner's Participation Agreement during their prior participation with HNS or whose contracts

were not renewed. In these circumstances, the decision by the Credentialing Committee is final. (Added November 2009.)

Effective August 10, 2010, at the discretion of the HNS Credentialing Committee, providers terminated for failing to adhere to the terms of the HNS Practitioner's Participation Agreement may be allowed to appeal the decision to terminate. HNS reserves the right to modify the decision to terminate if deemed the appropriate course of action. (Plan modified to reflect this change September 6th, 2010)

Once a provider has terminated his/her Practitioner's Participation Agreement or has been terminated by HNS, if that provider has questions that relate to quality issues that occurred during his/her tenure as a participating provider, such issues or questions will be responded to by the Credentialing Committee but must be submitted to the committee in writing. HNS will provide a written response to the provider's inquiry within 45 days from receipt of the written request. (Added above language February 2010.)

After termination or denial of participation, providers may re-apply to join the network after 36 months from the termination or date of denial (or at an earlier date if so approved by Committee). (modified for clarification 032611).

Upon any re-application, the provider must submit new and detailed descriptions of all malpractice issues, licensure issues, changes in practice patterns, any new education received, and details of any other issue pertinent to the processing of the re-application.

After a second denial of a credentialing application, HNS will no longer accept additional applications from that provider *unless there has been a substantive change in the circumstances surrounding the denial*. If so, any new information must be submitted *prior to the initiation of the credentialing process for the re-application*. The Credentialing Committee will review the information submitted to determine if there is reason to reconsider the applicant for participation in the HNS network. There is no guarantee that any application will be accepted or approved. If approved for admission to the provider network, the provider may be monitored as deemed appropriate by the Credentialing Committee.

- A. In the event HNS determines that a participating provider is subject to termination for cause, or without cause, the following procedure shall apply:
 1. After a review of the relevant information by the HNS Quality Assurance Committee and the HNS Credentialing Committee, the Credentialing Committee shall make a decision as to whether such provider shall be terminated from HNS participation.
 2. In the event the HNS Credentialing Committee determines termination of a provider from HNS participation is necessary, it shall so notify the provider by certified mail, return receipt requested or by commercial carrier. Such notices shall include the reasons for the termination, unless the termination is *without*

cause.

3. Except as otherwise stated above, the provider shall have 30 days from receipt of notice of termination to appeal the decision and to request a hearing for re-consideration of the decision to terminate. *All requests for reconsideration must be submitted to HNS, in writing, within 30 days from receipt of notice of termination and must include the reasons why the applicant feels that reconsideration should occur.* After receiving the written appeal for reconsideration, the Credentialing Committee will review the reasons set forth by the applicant and will either respond in writing to the provider within 30 days of receipt of the provider's appeal information or will schedule a hearing within 60 days of receipt of the written appeal. The time and date of a hearing will be communicated to the provider in writing. No less than three (3) members of the HNS Credentialing Committee must be present for hearing as well as the Chair of the HNS Quality Improvement Committee and HNS' Chief Executive Officer. The Credentialing Committee will make the final decision regarding reconsideration for participation in HNS.
4. All hearings will be held at the HNS offices in Cornelius, NC. The provider has the right to be represented at any such hearing by an attorney or any other person of the practitioner's choice *but may not be accompanied by more than one individual at any such hearing.* Additionally, at the discretion of HNS, counsel representing HNS may also be present.
5. At such hearings, the provider will be afforded an opportunity to present their reasons for requesting reconsideration. The HNS Chief Executive Officer (or Chair of the HNS QA Committee) will review the reasons for the provider's termination.
6. Following the hearing, the HNS Credentialing Committee will consider the provider's request for reconsideration and will notify the provider within 15 days of the date of the hearing, in writing, of the decision of the committee regarding reconsideration. All decisions of the HNS Credentialing Committee are final.

Annual Review of HNS Credentialing Plan

The HNS Credentialing Plan is reviewed at least once annually and includes a review of any changes to URAC and NCQA credentialing standards. Best efforts are made to assure that our program is consistent with NCQA and URAC standards for credentialing. Our Credentialing Plan is modified as often as necessary and is often updated quarterly to accommodate needed changes.

Only substantive and/or material changes to the HNS Credentialing Plan require approval of the HNS Credentialing Committee. Changes made for clarification of existing language do not require approval of the HNS Credentialing Committee. (Added

September 30th 2010)

Outsourcing of Services

The HNS Credentialing Program and Credentialing Plan is part of our Quality Improvement Program. HNS hereby attests that our organization does not delegate or outsource any of the services we provide, including credentialing services. All such services are provided either by members of the HNS Board of Directors, the staff and management of HNS.