Provider Services	ASPIRE HEALTH PLAN	Effective Date: 01/01/2014
	Provider Network Notification to Authorities and Practitioner Appeal Rights – CR 6	Policy #: AHP-PS006
		Review Date: 3/29/2024
		Applicable to: ☑ Medicare Advantage ☑ Commercia ASOI ☑ Anthem HMO ☑ Blue Shield Trio
	Approver's Name & Title: Gilly Guez, MD – Chief Medical Officer	

1.0 PURPOSE

1.1 If Aspire Health Plan (AHP) has taken action against a Practitioner for quality reasons, AHP reports the action to the appropriate authorities and offers the Practitioner a formal appeal process.

1.2 AHP must use objective evidence and patient-care consideration when deciding on a course of action for dealing with a Practitioner who does not meet its quality standards.

1.3 If AHP terminates or suspends a Practitioner for quality reasons, it must report to the appropriate authorities, including state licensing agencies, the National Practitioner Data Bank (NPDB), and AHP

1.4 Notification applies to Physicians and Non-Physicians for suspensions and terminations for quality reasons.

1.5 AHP must provide evidence that it followed its appeal process if it altered the conditions of a Practitioner's participation based on quality of care or service reasons.

1.6 Reporting to appropriate authorities is not applicable in the following circumstances:

1.6.1 If there are no instances of suspension, termination, restriction or revocation to report for quality reasons.

1.6.2 For automatic administrative terminations based on the Practitioners not meeting specific contractual obligations for participation in the network

1.7 All credentialing records and proceeds are confidential and protected to the fullest extent allowed by Section 1157 of the California Evidence Code, and any other applicable law.[1]

2.0 POLICY

[1] California Code, Evidence Code (EVID) section 1157

2.1 This policy applies to all AHP contracted Providers, regardless of network affiliation.

2.2 AHP must review participation of Practitioners whose conduct could adversely affect members' health or welfare, specify the range of actions that may be taken to improve practitioner performance before termination, report the Practitioner's actions to the appropriate authorities and make the appeal process know to Practitioners.

2.3 A Practitioner's status or participation in the AHP network may be denied, reduced, suspended, or terminated for any lawful reason, including but not limited to, a lapse in basic qualifications such as licensure, insurance, or required medical staff privileges or admission coverage at an AHP contracted Hospital; or a determination by AHP based on information obtained during the credentialing process that the Practitioner cannot be relied upon to deliver the quality or efficiency of Member care required by AHP.

2.4 AHPs policies and procedures regarding suspension or termination for participating Physician requires AHP to ensure that the majority of the hearing panel member are peers of the affected physician.

3.0 DEFINITIONS

3.1 Refer to AHP Definitions Manual

4.0 PROCEDURE

4.1 AHP must review participation of Practitioners whose conduct could adversely affect Members' health or welfare, specify the range of actions that may be taken to improve Practitioner performance before termination, inform practitioners of AHP's reports to the appropriate authorities and makes the appeal process known to Practitioners.[2]

4.2 A practitioner's status or participation in the AHP network may be denied, reduced, suspended, or terminated for any lawful reason, including but not limited to, a lapse in a basic qualification such as licensure, insurance, or required medical staff privileges or admission coverage at an AHP contracted Hospital; or a determination by AHP based on information obtained during the credentialing process that the Practitioner cannot be relied upon to deliver the quality or efficiency of Member care required by AHP. The Committee's involved for these reviews include but are not limited to, AHP's Provider Network Credentialing Committee and/or AHP's Peer Review Subcommittee.

4.3 AHP Provider Network Credentialing Committee is responsible for reviewing, approving and denying practitioners.

4.4 AHP's Provider Network Credentialing Committee is responsible for carrying out Member review, Practitioner or Provider grievances and/or appeals, Practitioner-related quality of care and service issue, including Facility Site and Medical Record Reviews, Sanctioning and Provider appeals for adverse credentialing decision. The Provider Network Credentialing Committee also performs the oversight of the credentialing activities of Delegates and that are delineated

[2] National Committee for Quality Assurance (NCQA), 2022 HP Standards and Guidelines, CR 6, Element A, Factor2

responsibilities for credentialing.

4.4.1 The range of actions that AHP may take to improve the Practitioner performance before termination, to, but are not limited to:
- 4.4.1.1 Profiling
- 4.4.1.2 Corrective actions(s)
- 4.4.1.3 Monitoring
- 4.4.1.4 Medical Record Audit

4.4.2 Practitioners have the right to appeal any adverse credentialing decision that impacts their participations status with AHP, in accordance with the appeals procedures provided herein. AHP will:

- 4.4.2.1 Provide written notification when a professional review action has been brought against a Practitioner, including reasons for the action.

- 4.4.2.2 Allow Practitioners thirty (30) calendar days to request a hearing/appeal.

- 4.4.2.3 AHP cannot have an attorney if the practitioner does not have attorney representation, to ensure compliance with CA business & Professions Code 809.3(c).[3]

- 4.4.2.4 Practitioner Appeal Process, AHP informs the affected Practitioner of its appeal process and includes the following information in the process and notification.[4]

- 4.4.2.5 AHP provides written notification, by FedEx delivery, return receipt requested, to any Practitioner denied participation within thirty (30) calendar days of the decision reached by the AHP Credentialing Committee or Peer Review Subcommittee. The written notice will indicate the following:

  - 4.4.2.5.1 A professional review action has been brought against the Practitioner.

  - 4.4.2.5.2 Reasons(s) for the action may include a brief description of the factual basis for the proposed action that includes but is not limited to:

    - 4.4.2.5.2.1 A lapse in basic qualifications such as licensure, insurance, or required medical staff privileges;

    - 4.4.2.5.2.2 A determination that the Practitioner cannot be relied upon to deliver the quality or efficiency of patient care desired by AHP;

    - 4.4.2.5.2.3 A determination that the Practitioner cannot be relied upon to follow

[3] National Committee for Quality Assurance (NCQA), 2022 Health Plan Standards and Guidelines, CR 6, Element A Factor 2; Business and Professions code section 809.3
[4] National Committee for Quality Assurance (NCQA), 2022 Health Plans Standards and Guidelines, CR 6, Element A Factor 2

AHP's clinical or business guidelines or directive;

4.4.2.5.2.4 Falsification of information provided to AHP;

4.4.2.5.2.5 Adverse malpractice history;

4.4.2.5.2.6 Adverse events that have potential for or have caused injury or negative impact to Members; and/or

4.4.2.5.2.7 Felony convictions

4.4.2.5.3 A summary of the appeal rights and process is provided in the provider manual and is included as an enclosure with the credentialing decision letter (See "AHP Peer Review Level I and Credentialing Appeal")

4.4.2.5.4 A statement that the Practitioner may request for an AHP Peer Review Level I Appeal and Credentialing Appeal, conducted by the AHP Provider Network Credentialing Committee who denied participation, is included in the decision letter, in accordance with this policy.

4.4.2.5.5 The Practitioner is notified that a request for an AHP Peer Review Level I Appeal Credentialing Appeal, must be requested by the Practitioner in writing, addressed to the AHP Committee Chairperson or Medical Director/Designee.

4.4.2.5.6 The practitioner is notified that the practitioner's request for an AHP Peer Review Level I Appeal and Credentialing Appeal, must be received within thirty (30) days of the date of receipt of the notice, by the Practitioner. The Practitioner's written request must include:

4.4.2.5.6.1 A clearly written explanation of the reason for the request; and

4.4.2.5.6.2 A request to exercise the right to present the appeal orally, if so desired per below

4.4.2.5.7 A summary of the Practitioner's Rights at the appeal includes the right to:

4.4.2.5.7.1 Present additional written material for review by the AHP Provider Network Credentialing Committee;

4.4.2.5.7.2 Present any information orally to the AHP Provider Network Credentialing Committee;

4.4.2.5.7.3 Notification that the AHP Peer Review Level I and Credentialing Appeal meeting takes place before the AHP Provider Network Credentialing Committee

4.4.2.5.7.3.1 The AHP Peer Review Level I and Credentialing Appeal

Meeting is not a hearing and procedural rights associated with the formal peer review hearings do not apply for adverse credentialing decisions.

4.4.2.5.7.3.1.1 At the AHP Peer Review Level I and Credentialing Appeal meeting, Practitioners may not be represented by a licensed attorney; however, they have the right to be represented by a non-attorney representative of their choice.

4.4.2.5.8 Practitioners not requesting an appeal within the required timeframe and as specified above, waives his/her rights to further appeals, and decision of the AHP Provider Network Credentialing Committee is final.

4.4.2.5.8.1 The decision will be adopted as the final action; and

4.4.2.5.8.2 The action, if implemented, AHP will report the final decision to the AHP Board of Directors, appropriate state licensing agency, and National Practitioner Data Bank (NPDB), as required under the California Business and Professions Code subsection 805 and 45 of Federal regulations, part 60.[5]

4.4.2.5.9 If an appeal is submitted in a timely manner, AHP arranges for review of the appeal to be conducted at the next scheduled meeting of the AHP Provider Network Credentialing Committee who made the decision to deny.

4.4.2.5.9.1 Prior to the meeting, AHP sends a written notice to the Practitioner to the Practitioner via FedEx, informing the Practitioner of the date, time and place of the meeting.

4.4.2.6 The AHP Provider Network Credentialing Committee meets to complete its evaluation and renders a decision to uphold or overturn the denial, the Practitioner is provided written notification of the appeal decision that contains specific reason for the decision, in writing within thirty (30) calendar days of the decision.

4.4.2.6.1 If the appeal decision by the AHP Provider Network Credentialing Committee is to uphold the original denial of the Practitioner's participation in the AHP network, the written notice will include:

4.4.2.6.1.1 The decision, including a brief description of the decision and the reasons for it.

4.4.2.6.1.2 A statement that the Practitioner may request for an AHP Peer Review Process and Level II Appeal, in accordance with this policy.

[5] California Business and Professions Code section 808; 45 Code of federal Regulations (CFR) section 60

4.4.2.6.1.3 A provided a copy of the AHP Peer Review Process and Level II Appeal (See “AHP Peer Review Process and Level II Appeal”)

4.4.2.6.1.4 The practitioner is notified that a request for an AHP Peer Review Process and Level II Appeal must be requested by the Practitioner in writing, addressed to the Chief Medical Officer

4.4.2.6.1.5 The Practitioner is notified that the Practitioner’s request for an AHP Peer Review Process and Level II Appeal, must be received within thirty (30) days of the date of receipt of the notice.

4.4.2.6.1.6 At the hearing, the Practitioner can be represented by an attorney or another person of the Practitioner’s choice. AHP cannot have an attorney, if the practitioner does not have attorney representation.

4.4.3 Practitioners not requesting an appeal within the required timeframe and as specified above waive their right to further appeals, and/or the decision of the AHP Provider Network Credentialing Committee is final.

4.4.3.1 The decision will be adopted as the final actions; and

4.4.3.2 The action, if implemented, AHP will report the final decision to the AHP Governing Board, Appropriate state licensing agency, and National Practitioner Data Bank (NPDB), as required under the California Business and Professions code subsection 805 and 45 of Federal Regulations, Part 60.

4.4.4 AHP complies with the reporting requirements of the Medical Board of California, the Dental Board of California, the Osteopathic Medical Board of California, the Board of Podiatric Medicine, the California Board of Behavioral Sciences, the Board of Psychology, and the Physician Assistant Board, and other licensing agencies, and National Practitioners Data Bank (NPDB) as required by law. AHP also complies with the reporting requirements of the California Business and Professions Code and the Federal Health Care Quality Improvement Act regarding adverse credentialing actions. Practitioners are notified of the report and its contents in accordance with the law.

4.4.5 The following types of Providers require 805 and 805.01 reporting:

4.4.5.1 Medical Doctors (MD)
4.4.5.2 Nurse Practitioners (NP)
4.4.5.3 Dentists (DDS)
4.4.5.4 Osteopaths (DO)
4.4.5.5 Podiatrists (DPM)
4.4.5.6 Marriage Family Therapists (MFT)
4.4.5.7 Licensed Clinical Social Workers (LCSW)
4.4.5.8 Psychologists (Psy.D., PhD.);
4.4.5.9 Physician Assistants (PA)

4.4.6 **805 Reports**

4.4.6.1 AHP is not required to file a separate report with respect to action attributable to the same medical disciplinary cause or reason.

4.4.6.1.1.1 If the Medical Board of California or a licensing agency of another state revokes or suspends, without a stay, the license of a Physician and Surgeon, a peer review body is not required to file an 805 report when it takes action as a result of the revocation or suspension.

4.4.6.1.1.2 If the California Board of Podiatric Medicine or a licensing agency of another state revokes or suspends, without a stay, the license of a doctor of podiatric medicine a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension.

4.4.6.2 If an 805 is reported, it shall include the following information:

4.4.6.2.1.1 The name of the licentiate involved;

4.4.6.2.1.2 The license number of the licentiate involved;

4.4.6.2.1.3 A description of the facts and circumstances of the medical disciplinary cause or reason;

4.4.6.2.1.4 Any other relevant information deemed appropriate by the reporter.

4.4.6.3 AHP must file an 805 report with the relevant agency within fifteen (15) days after the effective date on which any of the following occur as a result of an action of a peer review body:

4.4.6.3.1.1 A licentiate's application for staff privileges or membership is denied or rejected for medical disciplinary cause or reason.

4.4.6.3.1.2 A licentiate's membership, staff privileges, or employment is terminated or revoked for medical disciplinary cause or reason.

4.4.6.3.1.3 Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of thirty (30) days or more for any twelve (12) months period, for medical disciplinary cause or reason.

4.4.6.4 If a licentiate takes any action listed above, after receiving notice of a pending investigation initiated for a medical disciplinary cause or reason or after receiving notice that his or her application for membership or staff privileges is denied or will be denied for a medical disciplinary cause or reason, the chief of a staff or a medical or professional staff or other Chief Executive Officer, Medical Director, or administrator or any peer review body and the Chief executive officer or administrator or any licensed health care facility or clinic where the licentiate is employed or has staff privileges or membership or where the licentiate applied for staff privileges or membership, or sought the renewal

thereof, shall file an 805 report with the relevant agency within fifteen (15) days after the licentiate takes the action

4.4.6.4.1.1 Resigns or takes a leave of absence from membership, staff privileges or employment.

4.4.6.4.1.2 Withdraws or abandons his or her application for staff privileges or membership.

4.4.6.4.1.3 Withdraws or abandons his or her request for renewal of staff privileges or membership.

4.4.7 **805.01 Reports**

4.4.7.1 AHP must file an 805.01 within fifteen (15) days after a credentialing committee or peer review body makes a final decision or recommendation of termination, suspension or restriction of staff privileges, membership or employment due to an investigation, for at least one (1) of the following reasons:

4.4.7.1.1.1 Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one (1) or more patients in such manner as to be dangerous or injurious to any person or the public.

4.4.7.1.1.2 The use of, or prescribing for or administering to him/herself, any controlled substances; or the use of any dangerous drug, as defined in section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, or any other persons, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely.

4.4.7.1.1.3 Repeated acts of clearly excessive prescribing, furnishing or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason therefor.

4.4.7.1.1.4 Sexual misconduct with one (1) or more patients during a course of treatment or an examination.

4.4.8 National Practitioner Data Bank (NPDB)

4.4.8.1 Reports must be submitted to the NPDB within thirty (30) days of the action.

4.4.9 Health Plan Reporting

4.4.9.1 Reports must be submitted AHPs Credentialing Manager, within thirty (30) days of the action.

4.5 AHP policies and procedures regarding suspension or termination of a participating Physician requires AHP to ensure that the majority of the hearing panel members are peers of the affected

Physician.[6]

4.5.1 A Peer is appropriately trained and licensed Physician in a practice similar to that of the affected Physician.

4.5.2 Panel members do not have to possess identical specialty training.

4.5.3 Policies and procedures do not always have to state the word “majority”, but at least 51% of the members must be peers.

5.0 TRAINING

5.1 Training is provided to each employee at the new employee orientation within 90 days of hire, when there are updates to the policies, and annually thereafter.

6.0 REVIEW PERIOD

6.1 Regulatory and compliance policies are reviewed by the Policy Owner annually at a minimum (more frequently if a change, regulatory or otherwise, that causes a change to the policy).

7.0 REGULATORY REQUIREMENTS AND REFERENCES

7.1 National Committee for Quality Assurance (NCQA), 2022 HP Standards and Guidelines

8.0 POLICY VIOLATION

8.1 Any AHP associate or contractor who fails to abide by this policy may be subject to disciplinary action, up to, and including termination. Please refer to AHP’s Disciplinary Guidelines and Enforcement Policy for further details.

[6] Medicare Managed Care Manual, Chapter 6 “Relationships with Providers”. Section 60.4