WPPA, INC. PROVIDRS CARE

POLICIES AND PROCEDURES

A. PROFESSIONAL PROVIDER CREDENTIALING PROCEDURE

Once a provider has completed the application, credentialing is begun. The following outline represents the credentialing procedure. (Primary Source Verification (PSV) is performed by Network or its designee.)

Responsibility	Action
Network Staff	Sends physician/provider an application including a Consent/Release Authorization form as well as a cover letter.
Provider	Returns completed application, signed attestation or release and requested additional documentation to Network. Attestation includes providers' response to all professional questions, health status questions and any limitation of privileges or disciplinary action.
PSV	Receives the completed application from the Provider/Network, checks the package for completeness, including documentation and additional explanations as requested on the application and signed attestation. Obtains any missing information and/or clarification of discrepancies or returns the application to the provider for completion. Performs Primary Source Verification (PSV) or Network may perform PSV services.
PSV	Inquires with the following for primary source verification of information provided by the applicant: 1. State Board of Medical Examiners in state(s) in which the applicant is currently practicing. 2. National Technical Information Services tapes or Verify a copy of the DEA or controlled dangerous substance certification is valid and current in state(s) in which the applicant is currently practicing. Registration Certificate provided by the applicant for verification. Acceptable verification sources: - DEA or CDS agency - DEA or CDA certificate - Documented visual inspection of the original DEA or CDS certificate - Confirmation from NTIS database - Confirmation from the AMA physician Masterfile (DEA only) - Confirmation from the state pharmaceutical licensing agency (where applicable) 3. For providers outside of Kansas; a copy of the state's BNDD Certificate for verification. 4. Educational institution for Residency or highest level of education or training, or in the case of a foreign graduate who has not completed a U.S. residency program, ECFMG. Verified by licensing board, PCN confirmation annually.

	5. AMA Profile or by phone/fax/internet to the specialty board, American Osteopathic Association Directory or by phone/fax/internet to the specialty board, American Board of Oral and Maxillofacial Surgery or by phone/fax/internet, American Board of Podiatric Medicine or by phone/fax/internet, American Board of Foot and Ankle Surgery or by phone/fax/internet. ABMS verification of Board Certification in the practicing specialty precludes the necessity of verifying education. 6. Hospital designated on application at which applicant is privileged, not verified, documented in writing as provided by the applicant. 7. Work history within medical specialty for past five years, not verified, documented in writing as provided by the applicant. 8. National Practitioner Data Bank report for verification of malpractice and disciplinary Medicare/Medicaid sanction history or exclusion. 9. Kansas Board of Healing Arts or appropriate state licensing board and the NPDB for verification of license sanctions.
PSV	Performs secondary source verification of information provided and attested by the applicant: 1. Copy of the Certificate of Insurance provided by the applicant for verification of required professional liability coverage. 2. Certification, as applicable. 3. Reasons for any inability to perform the essential functions of the position, with or without accommodation. 4. Lack of present illegal drug use. 5. History of loss of license and felony convictions. 6. Correctness and completeness of the application.
PSV	Makes 3 primary source attempts over a 60-day period. If no response is received, the Network Staff is advised.
PSV	Advises Network of failure to obtain required verifications and/or send profile to Network, within 90 days.
Network Staff	Determines whether enough information exists to present the file to the Membership Committee.
PSV	Prepares a file summary for all providers for whom complete documentation and verification exist for the Membership Committee. Verification information presented must be no more than 180 days old at the time of review.
PSV	Maintains the original file consisting of the application, file summary and all supporting documentation, including primary source verifications.
Network Staff	Will notify the practitioner in writing of any information received as result of the credentialing process which varies substantially from the process which was provided by the practitioner. The practitioner will then be given two weeks in which to correct erroneous information before the file is reviewed by the Membership Committee.
Membership Committee	Reviews file and makes a recommendation of the provider's status to the Board of Directors.

Network Board	Approves or denies participation.
Network Staff	Notifies provider within 60 days of the Membership Committee determination and documents basis for failure to meet criteria, if any.
Provider	May request a reconsideration or appeal from the Membership Committee within 30 days of negative decision.
Membership Committee	May reverse denial decision based on additional information or may uphold the denial decision.
Network Staff	Notifies provider of Membership Committee's decision.
Network Staff	Notifies payors, employers and TPAs by providing needed information from provider profile in provider database.
Provider	If denial decision is upheld, the applicant's next step is to appeal to the Appeals Board (see Section IV. J).

B. CREDENTIALING STATUS DEFINITIONS

During the peer review process, the Membership Committee may elect to use one of four credentialing status definitions. The four status definitions are:

1. **Routine/Standard-Active Status** - successful achievement by provider of criteria established by the Network Board of Directors necessary to remain a full Active member of Network for three (3) years or for a shorter designated time.
2. **Deferred/Tabled Status** - action on the application of the provider for membership in Network is deferred for additional information and the application is considered at a later date. Network will seek additional information to be reviewed by the Membership Committee.
3. **Termination Status** - provider has failed to meet criteria required for continued membership in Network.
4. **Provisional Credentialing Status** – provider who has not achieved or satisfied all the criteria established by Network Board of Directors necessary to become an Active member of the network, but has successfully completed a preliminary review by the CVO and network staff, can be admitted/retained to the network for a temporary period of sixty (60) days or less, provider may also be limited to current medical group practice.
5. **Watch Status** – successful achievement by provider of criteria established by the Network Board of Directors necessary to remain a full Active member of Network for one (1) year or for a shorter designated time.

C. RE-CREDENTIALING PROCEDURE FOR PROFESSIONAL PROVIDER

Once a provider has become a member of the Network, he or she is re-credentialed at least every three (3) years or earlier as determined by the Membership Committee during initial credentialing. Providers with watch status are recredentialed annually or sooner depending on the decision of Membership Committee. The following outline represents the recredentialing procedure.

Responsibility	Action
Network Staff	Produces a list of providers due for recredentialing.
PSV	Produces a recredentialing profile (application), attestation or a release and mails, faxes or emails to provider for update.
Provider	Returns updated recredentialing profile, signed attestation or release to PSV for update to provider file. Attestation includes providers' response to all professional questions, health status questions and any limitation of privileges or disciplinary action.
PSV	Inquires with the following for primary source verification of information provided by the applicant: 1. State Board of Medical Examiners in state(s) in which the applicant is currently practicing. 2. National Technical Information Services tapes or Verify a copy of the DEA or controlled dangerous substance certification is valid and current in state(s) in which the applicant is currently practicing. Registration Certificate provided by the applicant for verification. Acceptable verification sources: • DEA or CDS agency • DEA or CDA certificate • Documented visual inspection of the original DEA or CDS certificate • Confirmation from NTIS database • Confirmation from the AMA physician Masterfile (DEA only) • Confirmation from the state pharmaceutical licensing agency (where applicable) 3. For providers outside of Kansas; a copy of the state's BNDD Certificate for verification. 4. Educational institution for Residency or highest level of education or training, or in the case of a foreign graduate who has not completed a U.S. residency program, ECFMG. Verified by licensing board, PCN confirms annually. 5. AMA Profile or by phone/fax/internet to the specialty board, American Osteopathic Association Directory or by phone/fax/internet to the specialty board, American Board of Oral and Maxillofacial Surgery or by phone/fax/internet, American Board of Podiatric Medicine or by phone/fax/internet, American Board of Foot and Ankle Surgery or by phone/fax/internet. ABMS verification of Board Certification in the practicing specialty precludes the necessity of verifying education. 6. Hospital designated on application at which applicant is privileged, not verified, documented in writing as provided by the applicant. 7. Work history within medical specialty for past five years, not verified, documented in writing as provided by the applicant. 8. National Practitioner Data Bank report for verification of malpractice and disciplinary Medicare/Medicaid sanction history or exclusion. 9. Kansas Board of Healing Arts or appropriate state licensing board and the NPDB for verification of license sanctions.
PSV	Performs secondary source verification of information provided and attested by the applicant: 1. Copy of the Certificate of Insurance provided by the applicant for verification of required professional liability coverage. 2. Reasons for any inability to perform the essential functions of the position, with or without accommodation. 3. Lack of present illegal drug use. 4. History of loss of license and felony convictions. 5. Correctness and completeness of the application.

Network Staff	Determines whether enough information exists to present the file to the Membership Committee.
PSV	Prepares a file summary for all providers for whom complete documentation and verification exist. Information included in the file may be no more than 180 days old at the time of review.
Membership Committee	Reviews file and makes a recommendation of the provider's status to the Board of Directors.
Network Board	Approves or denies participation.
Provider	May request a reconsideration or appeal from the Membership Committee within 30 days of negative decision.
Membership Committee	May reverse denial decision based on additional information or may uphold the denial decision.
Network Staff	Notifies provider of Membership Committee's decision.
Provider	If denial decision is upheld, the applicant's next step is to appeal to the Appeals Board (see Section IV. J).

D. ONGOING MONITORING OF SANCTIONS, COMPLAINTS, AND ADVERSE EVENTS POLICY

Ongoing Monitoring of Sanctions, Complaint, and Adverse Events will be performed on participating providers, and, when appropriate, action on important safety, care or service issues will be taken according to the Disciplinary Procedures outlined in Section I. Reports from the following sources shall be reviewed for the presence of any providers participating in the Network within thirty (30) calendar days of its release:

1. Medicare and Medicaid sanction reports
2. Licensing boards
3. Complaints
4. Adverse Events

PROCEDURE

Responsibility	**Action**
Network Staff	Review State Board Actions/Medicare/Medicaid sanction reports every month.
Network Staff	Maintain and review physician service complaints or reports of adverse events on a monthly basis.
Network Staff	Present to the Membership Committee for review any sanction or license action taken within (30) days of receipt.
Network Staff	Investigate all service complaints or adverse events and present to the Membership Committee any significant findings regarding quality of care within (30) days of receipt.
Membership Committee	Review sanction or complaint and make recommendations to the Network Board.
Network Board	Review Membership Committee recommendation within (30) days and determine proper action as defined in Section IV, I, Disciplinary Procedures.
Network Staff	Document all Committee or Board reviewed information and action in provider's credentials file.

E. MALPRACTICE HISTORY DEVELOPMENT

POLICY

Network will review the malpractice history provided by the applicant and obtained through the National Practitioner Data Bank to assist in the decision to grant or continue participation status to providers. Refer to Network Credentialing Criteria for details regarding satisfactory malpractice history.

PROCEDURE

If additional information is needed for malpractice cases that are "pending" the Network Staff or Membership Chairman will contact physician or office for additional information.

F. IMPAIRED PROVIDERS (due to chemical dependency)

POLICY

Network shall not grant participation status or will revoke existing status if there is evidence of impaired judgment or performance due to chemical dependency.

Applicants with a history of chemical dependency within the past five (5) years must meet the advocacy requirements of the appropriate medical association.

PROCEDURE

When chemical dependency problems are noted on the application or should a member of the Membership Committee suspect a history of chemical dependency, each case will be investigated by Network Staff prior to presenting the application to the Membership Committee.

Responsibility	**Action**
Network Staff	Case is discovered.
Network Staff	Case is referred to Membership Chairman
Network Staff	Letters are sent to: 1. Applicant to determine the nature of the condition and/or the treating facility/providers. 2. Treating facility or provider to determine if the program was completed and to determine the after care arrangements. 3. Appropriate medical association to determine if the applicant has been in the program and if there was successful completion.

G. IMPAIRED PROVIDERS (due to physical and manual health)

POLICY

Applicants with documented impairment over the age of 70 will submit an annual written report from their physician confirming their mental and physical health.

Network shall not grant participation status or will revoke existing status if there is evidence of impaired judgment or performance due to a physical or psychiatric health condition.

PROCEDURE

When physical or psychiatric health problems are noted on the application or should a member of the Membership Committee suspect a history of physical or psychiatric health problems, each case will be investigated by the Network Staff prior to presenting the application to the Network Membership Committee.

Responsibility	**Action**
Network Staff	Case is discovered.
Network Staff	Case is referred to the Medical Director
Medical Director	Letters are sent to: 1. Applicant to determine the nature of the condition and the identification of necessary on-going treatment for the condition. 2. Treating facility/provider to determine if applicant can safely perform duties without impairment of judgment or performance.

H. PROVIDER PRACTICING WITHOUT BOARD CERTIFICATION

POLICY

Network providers are to meet the Board Certification requirements in Section II-B. Exceptions to this policy are identified for two categories of providers:

1. Board Certified providers, who are practicing in a subspecialty without subspecialty Board Certification. (Ex. Oncologist practicing pediatric oncology.)

PROCEDURE

Under the direction of the Chairman of the Membership and Peer Review Committee, the Network Staff will send current hospital letter requesting privileging information regarding the applicant.

If the privileging is granted by the hospitals, the applicant will be recommended for participation status.

If the privileging is not granted by the hospitals, the applicant will not be granted participation status for the subspecialty.

Board Certified providers, whose practice is in a different primary specialty without Board Certification. (Surgeon practicing Emergency Medicine).

PROCEDURE

Applicant must meet requirements stated in Section II-B.

I. DISCIPLINARY PROCEDURES

Providers who provide medically unnecessary care, who are not accountable for pre-certification review, who engage in inappropriate utilization of health care resources, are in breach of contract provisions, or who demonstrate poor judgment, quality of care, unprofessional conduct, questionable competence or other inappropriate actions as determined by the Board of Directors, may lose their participation status with the Network.

The following Table illustrates the categories and the disciplinary process applied to each level of infraction:

DISCIPLINARY PROCEDURES			
Category	**1st**	**2nd**	**3rd**
Failure to participate with UR	Warning in writing	Warning in writing, possible escalation or termination	Warning in writing, possible escalation or termination
Unnecessary Care	Warning in writing	Warning in writing, possible escalation or termination	Warning in writing, possible escalation or termination
Cont. Breach	Warning in writing	Warning in writing, possible escalation or termination	Warning in writing, possible escalation or termination
Quality Breach	Warning inwriting	Warning in writing, possible escalation or termination	Warning in writing, possible escalation or termination

Infractions are noted in writing in the provider credentials record and are reviewed on a twelve-month basis. Flagrant violations may be reviewed by the committee immediately and appropriate action taken. The Network presents the record of infractions to the Membership Committee as specified in the Table. If, in the opinion of the Membership Committee, a provider does not meet minimal criteria as defined in the Credentialing-Recredentialing Criteria Practitioners or accumulates excessive warnings, the Network's Board of Directors will notify the provider of the decision to place on probation for a designated period of time, restrict privileges or terminate the Network participation contract. The right and procedures to appeal the decision are provided in the notification.

The Appeal process for this action is the same as for denial or termination as a result of credentialing or recredentialing.

Any action to restrict, suspend or terminate a provider's clinical privileges or plan participation, which is based on professional competence or professional conduct, for more than 30 days will be reported to the state licensing board and/or National Practitioner's Data Bank.

Within 15 calendar days of the effective date of the final action, the Manager responsible for credentialing reports the action to the following authorities:

- All appropriate state licensing agencies
- National Practitioner Data Bank (NPDB)

A letter is then written to the appropriate state licensing boards describing the adverse action taken, the practitioner it was taken against and a copy of the NPDB report is attached to the letter. This letter is sent certified to the appropriate state licensing boards within 24-hours of receiving the final NPDB report. A copy of this letter is filed into the Practitioner's credentials file.

Actions that are not reportable to the NPDB or licensing board are those that, in general, do not reduce, restrict, suspend, revoke, deny, or fail to renew clinical privileges or membership. Furthermore, actions that are not based on a physician's professional competence or behavior do not have to be reported.

The following are not reportable to the state licensing board and/or NPDB:

1. Censures, reprimands, or admonishments that do not adversely affect a physician's clinical practice or privileges.
2. A requirement that a physician have consultations on certain cases, retrain, receive additional training or attend continuing education classes.

3. Any withdrawal of an application for appointment or participation before the board takes final action.
4. Administrative suspensions such as those given to physicians for failing to meet reporting and other administrative requirements.
5. A voluntary relinquishing of participation as long as the physician is not under investigation for professional competence or conduct (but not if participation is relinquished in return for canceling an investigation).
6. Leaves of absence to enter a drug, alcohol, or psychiatric rehabilitation.

J. APPEALS/DUE PROCESS

If an invited provider has been denied participation with Network, reconsideration and an appeal process are available to the provider. In the event an applicant pursues legal recourse, and the case is decided in favor of Network, the applicant is responsible for all attorney fees. The following outline represents these processes.

Responsibility	**Action**
Network Staff	Notifies provider in writing reasons of denied participation decision including a summary of the appeals process.
Network Staff	Action will be reported within 30 days of the Membership Committee determination to the NPDB and to the Kansas Board of Healing Arts or the appropriate licensing board.
Provider	May request reconsideration from the Membership Committee within 30 days. Provider must provide clarification of or additional, new information.
Membership Committee	May recommend a reversal of the non-participation decision based on additional information, or may uphold the non-participation decision.
Network Board	Approves or denies a reversal.
Network Staff	Notifies provider in writing of Membership Committee's decision to uphold or Board decision regarding reversal.
Provider	If non-participation decision is upheld, the applicant may appeal to the Board of Directors within 30 days of the denial.
Network Board	Notifies applicant of the Appeals Board review process.
Appeals Board	Conducts the Appeals Board hearing and makes a final determination.
Appeals Board	Notifies provider in writing of final status within 60 days.
Network Staff	Updates system and produces a revised delegated provider profile.

K. DELEGATED CREDENTIALING TO OTHER ENTITIES

The credentialing process may be delegated by contract to a contracted IPA or group medical practice. The Network Staff and/or Membership Committee will perform a pre-audit review of the external entity's provider application and credentialing plan to ensure compliance with NCQA standards, CMS and Network's application, criteria, policies and procedures. The pre-audit will include a review of credentialing and recredentialing files. If the delegate is NCQA Accredited, a file review is not required. The external entity's plan must conform to the Network credentialing plan and the credentialing criteria must meet or exceed the Network credentialing criteria in order to be approved by the Membership Committee. The entity's Credentials Committee must be constructed to meet state and federal requirements for Peer Review. The entity must agree to permit Network and NCQA access to credentialing files and Credentials Committee minutes, or a written summary of such minutes.

Network's Membership Committee will provide the criteria to the external entity and will assist the entity in developing a satisfactory credentialing plan.

Network's Membership Committee has the ultimate authority for credentialing providers. The Network retains the right to approve new providers and to terminate or suspend individual providers. The Membership Committee, at its discretion, will review any credentialed provider as well as all exceptions granted by the external entity. The entity must notify the Network within 5 working days of any changes in status of the providers, including but not limited to termination, resignation, changes in privileges, probation, or other disciplinary action.

The Network Membership Committee will review the entity's credentialing and reappointment or recertification processes at least annually. This will include a review of the credentialing plan, including criteria, using the 8/30 methodology.

Review of the provider files will include the following to determine file adequacy: Orderly, consistent format and organization

1. Completed, legible application
2. Signed attestation
3. Copies of Primary Source verification of the following:
    a. board certification
    b. education, if not Board Certified
    c. appropriate license(s)
    d. malpractice claims history
    e. copies of DEA certificate, BNDD certificate, privilege status at primary admitting facility, and malpractice coverage.
4. Copies of Provider Authorization/Release and Delegation Release.
5. Report of work history.
6. Documentation of adverse professional actions, e.g. Hospital suspensions or limitations, Medicare/ Medicaid suspension, DEA investigations/actions, state licensing investigations/ actions.
7. Documentation and appropriateness of disciplinary actions.
8. Documentation of Recredentialing conducted at least every three years with Primary Source verification as prescribed and QA/QI information provided by NETWORK Quality Management.
9. Evidence of Peer Review and due process.
10. Review of Credentialing Plan and Credentials Committee minutes.

If audit findings indicate discrepancies of credentialing criteria, the Membership Committee may rescind the delegation and conduct internal credentialing. The committee will routinely monitor and evaluate the delegated credentialing process.

If deficiencies are found during the audit, WPPA, ProviDRs Care may develop a corrective action plan for the delegated entity, to correct deficiencies in its credentialing process. WPPA, ProviDRs Care may conduct an independent investigation into the credentials and/or professional conduct of any applicant or participating provider. Delegated entity shall permit WPPA, ProviDRs Care timely and reasonable access to all credentialing documents and related files.

L. DELEGATED CREDENTIALING FOR OTHER ENTITIES

The credentialing process may be delegated to the Network by a Managed Care Organization or other entity. The Network Staff will review the external entity's provider application and credentialing requirements for variances with the Network's application, criteria, policies and procedures. If there are variances, the CC will determine whether the required changes are acceptable. If not acceptable, the CC or its representative will notify the entity representative and make an attempt to resolve the differences. The CC will present its recommendations to the Board.

If an agreement is signed with the entity, the Network will agree to allow the entity and NCQA access to credentialing files and credentials committee minutes (or a written summary of such minutes).

As part of the application process, the Network providers will sign a "Delegated Credentialing Release" which allows the plan to provide information obtained during credentialing which is required by the external entity.

This is in addition to the Network release the provider must sign.

The external entity must provide full disclosure of the basis for a decision not to credential a provider or to take disciplinary action, including termination. The entity must have an appeals process, which is offered to the provider.