Corrective Action Policy for Health Care Providers

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Corrective Action Policy

1. PURPOSE

The purpose of this policy is to ensure Blue Cross Blue Shield of North Dakota (BCBSND) implements timely, effective actions when indicators reveal a need for improved performance by a Health Care Provider. This policy outlines how BCBSND may initiate a corrective action if a Health Care Provider does not comply with BCBSND's performance standards. As a member owned organization, BCBSND has a responsibility to ensure payments are not made for unnecessary, inappropriate or harmful services.

2. SCOPE

2.1. Identify and advise Health Care Providers and their respective Provider Group when patient care and services are inappropriate or not provided within acceptable standards of medical practice.

2.2. Intervene when patient care and services may be detrimental, inefficient or substandard.

2.3. Intervene when a Health Care Provider's practices result in identified Fraud, Waste, or Abuse.

2.4. Provide a mechanism to identify Health Care Providers unwilling or unable to provide patient care and services in accordance with established standards.

2.5. Recommend corrective action and follow-up to assure the problem identified or the medical practice will not be repeated.

2.6. Comply with State Board of Examiners actions and other state laws.

3. SOURCES

The guidelines used to monitor performance standards include:

3.1. Compliance with BCBSND's policies and procedures.

3.2. Compliance with generally accepted standards of care and clinical competence.

3.3. Appropriateness of professional conduct.

4. PERFORMANCE STANDARDS

4.1. The following is a non-exclusive summary of BCBSND's performance standards: Health Care Providers shall:

a. Provide or order medically necessary and appropriate services for members.

b. Comply with accepted professional standards of care, conduct, competence, practices and reputation.

c. Comply with BCBSND Medical Policy and coding and billing standards, including, but not limited to:

i. Published BCBSND policies and procedures; any published BCBSND policy or standard will supersede all other applicable standards or policies

ii. Nationally accepted billing and coding standards where BCBSND has not specifically published any policy or standard; and

d. Engage in accepted practice patterns that are not aberrant, excessive or inappropriate.

Additionally, participating Health Care Providers shall:

e. Cooperate, in good faith, to facilitate BCBSND's Quality Management and Fraud, Waste, and Abuse Program activities. Such cooperation includes returning telephone calls, responding to written inquiries or requests from BCBSND, providing information and documents requested by BCBSND and cooperating with BCBSND staff members as they perform their activities.

f. Obtain prior authorization of services in accordance with applicable Utilization Management Program policies and procedures.

g. Comply fully with the terms of their participation agreement(s).

h. Continue to satisfy BCBSND's credentialing requirements, including, without limitation:

i. Licenses or certifications must be in good standing.
ii. Liability insurance coverage must remain in full force and effect.
iii. No unreported material changes in the Health Care Provider's status such that the credentialing information submitted to BCBSND is no longer accurate.

4.2. This policy does not apply in the following instances:

a. Non-acceptance of a participation application because the Health Care Provider fails to satisfy BCBSND's pre-credentialing application standards (e.g. failure to provide evidence of licensure or insurance).

b. Disputes intended to be resolved according to BCBSND's appeals process.

5. DEFINITIONS

Abuse: Excessive or improper use of health care services or actions that are inconsistent with acceptable business and/or medical practice resulting in unnecessary costs. Abuse refers to incidents that, although not considered fraudulent acts, may directly or indirectly cause financial losses to the members or the organization.

Corrective Action Plan: A formally defined disciplinary process, intended to direct a Health Care Provider back into compliance with the performance standards, during which, for a specified period of time, practice restrictions can be imposed and/or payment for care administered by a Health Care Provider can be denied, restricted or reduced for all or certain services.

Fraud: An intentional act of deception, misrepresentation or concealment of material fact or information in order to gain something of value

Fraud, Waste, and Abuse Committee: Committee responsible for reviewing the functions of the Fraud, Waste, and Abuse Program, with oversight by the Quality Committee of the Board. Members of this committee include representatives from the following areas: Special Investigations Unit, Compliance and Corporate Ethics, Claims Administration, Health Network Innovations, Customer Contact Center & Legal.

Fraud, Waste, and Abuse Program: The program includes all activities to prevent, detect, investigate and resolve concerns of fraud, waste, and abuse.

Health Care Provider: A person or facility licensed, certified, or otherwise authorized by state law to provide health care services.

Non-participating: A Health Care Provider that does not have or is not subject to a participation agreement.

Non-payable: A Health Care Provider that is not reimbursable. No benefits are available for covered services prescribed by, performed by or under the direct supervision of a non-payable Health Care Provider.

Provider Group: A legal entity that has entered into a participation agreement with BCBSND.

Quality Committee of the Board: The Committee responsible for overseeing and directing the Quality Management Program. This subcommittee of the Board of Directors consists of five (5) Directors, appointed and designated by the Chairman of the Board.

Quality Management Committee: The Committee responsible for coordinating the functions of credentialing, medical management, utilization management, case management, quality management and improvement initiatives with oversight by the Quality Committee of the Board of Directors. Members of this Committee include representatives from the following areas: Clinical Excellence and Quality, Health Innovation and Practice Transformation, Customer Contact Center, Claims Administration, Special Investigations Unit, and Legal.

Quality Management Program: The Program provides planned, systematic activities and processes to monitor and evaluate patient care and services for the primary purpose of assisting Health Care Providers to improve quality.

Special Investigations Unit and Provider Audit: Unit responsible for administering the Fraud, Waste, and Abuse Program.

Waste: Mismanagement, overutilization of services, under or ineffective use of treatments or medication, inadequate oversight, or other practices that result in unnecessary costs. These costs can be eliminated without reducing the quality of care.

6. INVESTIGATION

6.1. Internal and external concerns regarding any apparent non-compliance with the performance standards will be reviewed by the Director of Quality Management or Special Investigations Unit and Provider Audit Manager to assign leadership of the investigation. A resource team, of which membership will be variable based on the concern addressed, will investigate the concern.

The Director of Quality Management or Special Investigations Unit and Provider Audit Manager will coordinate investigation results with a Medical Director as appropriate. If sufficient cause for

concern is noted, the results will be forwarded to the Quality Management Committee and/or the Fraud, Waste, and Abuse Committee at the next regularly scheduled meeting(s) or at a special meeting called to consider the matter.

6.2. An investigation will be conducted regarding the concerns presented to determine areas where intervention is most likely to provide improvements in compliance with the performance standards. Data sources for the investigation may include but are not limited to:

- High volume, high-risk procedure and diagnostic reports
- Inpatient indicators such as readmission rates
- Health Care Provider profile reports, which identify Health Care Provider(s) whose practices do not fall within group parameters established on an analysis of utilization patterns
- Drug utilization and Health Care Provider prescribing reports
- Utilization and claim reports
- Appeals and complaints filed by members and Health Care Providers
- State Board of Medical Examiners or other Professional Boards
- Health Care Providers, members and employers
- Member and Health Care Provider satisfaction surveys
- Any other report which may provide relevant and credible information

6.3. Participating Health Care Providers and Provider Groups must submit requested information and fully cooperate with staff members as a condition of their continued participation with BCBSND. The Quality Management Committee or Special Investigations Unit and Provider Audit may, at their discretion do any or all of the following:

a. Consult with the Health Care Provider and/or Provider Group concerning the alleged non-compliance;

b. Review material documents, including members' medical records and other specified information submitted by the Health Care Provider or Provider Group upon request;

c. Contact other Health Care Providers or persons who have knowledge concerning the matter being investigated;

d. Submit information regarding the Health Care Provider's conduct to another committee or department (i.e. Quality Management Committee orFraud, Waste and Abuse Committee) for further consideration and action.

6.4. Upon determining that a **participating** Health Care Provider or Provider Group has not complied with the performance standards, the Quality Management Committee or Fraud, Waste and Abuse Committee may initiate a Corrective Action Plan.

6.5. Upon determining that a **non-participating** Health Care Provider has not complied with performance standards, the Quality Management Committee or Special Investigations Unit and Provider Audit shall communicate to the Health Care Provider in writing:

a. The manner in which the practice was found to be excessive, inappropriate, or substandard.

b. A statement that the Health Care Provider has no less than six (6) months from the date of the notice to modify the identified practice.

c. A statement that failure to modify the identified practice may result in the provider being placed in a non-payable status.

6.6. The Quality Management Committee will communicate all decisions and recommendations to the Quality Committee of the Board through the Quality Management Committee meeting minutes. The Special Investigations Unit and Provider Audit will communicate all decisions and recommendations to the Quality Committee of the Board through the Fraud, Waste, and Abuse Committee's meeting minutes.

7. PROCEDURE FOR IMPOSING A CORRECTIVE ACTION PLAN

7.1. The Quality Management Committee or Special Investigations Unit and Provider Audit shall notify the Health Care Provider and the Provider Group in writing within ten business days that a Corrective Action Plan will be imposed. The Corrective Action Plan shall become effective as of the date of the notice letter, unless the Quality Management Committee or Fraud, Waste and Abuse Committee elects to defer the effective date to a date specified in the letter.

The Health Care Provider or Provider Group is permitted to see any records accumulated regarding the Quality Management Committee's investigation pertaining to the Health Care Provider's practice at any time. The Special Investigations Unit and Provider Audit investigation records will not be available for review by the Health Care Provider or Provider Group, unless otherwise required by law.

7.2. The written Corrective Action Plan may include the following:

a. Identification of the Health Care Provider(s) or Provider Group involved

b. A description of the complaint or violation.

c. A description of the investigation process.

d. A description of the corrective action, including associated activities and timelines, which may include, but is not limited to:
   - Counseling the Health Care Provider(s) and Provider Group concerning specific actions that should be taken to address identified problems
   - Including claim submission requirements
   - Mandatory prior authorizations for specified treatments or services
   - Continuing education
   - Closure of the Health Care Provider or Provider Group's practice to new members
   - Any other actions deemed appropriate

e. A list of the activities the Quality Management Committee or Special Investigations Unit and Provider Audit will use to monitor compliance and effectiveness of the corrective action related to the incident.

f. A statement that the Health Care Provider and/or Provider Group has no less than six (6) months from the receipt of the notice to make corrections.

g. A statement that the investigation and Corrective Action Plan will be reviewed six (6) months from receipt of this notice. Results of the review will be reported to the Quality Committee of the Board as appropriate.

h. A statement indicating that the Corrective Action Plan cannot be appealed.

i. If applicable, a statement that the Corrective Action Plan will be reported to the North Dakota Department of Insurance, State licensing board or other entities as mandated by law.

8. CORRECTIVE ACTION PLAN REVIEW

8.1. All Corrective Action Plans are reviewed after six (6) months. The Director of Quality Management presents its recommendation at the next regularly scheduled meeting of the Quality Management Committee. The Special Investigations Unit and Provider Audit presents its recommendation at the next regularly scheduled meeting of the Fraud, Waste, and Abuse Committee.

a. If the Quality Management Committee or Fraud, Waste, and Abuse Committee determines that the Corrective Action Plan has been satisfactorily completed, the Health Care Provider and Provider Group will be notified;

b. If within 24 months of the completion of the Corrective Action Plan, it is determined the Health Care Provider or Provider Group is no longer complying with performance standards:

i. The Quality Management Committee or Fraud, Waste, and Abuse Committee may re-instate a Corrective Action Plan, without opportunity for appeal.; or
ii. The Quality Management Committee or Fraud, Waste, and Abuse Committee may elect to convert the participating provider or Provider Group to non-participating status; or

iii. The Quality Management Committee or Fraud, Waste, and Abuse Committee may submit a request to recommend converting the provider or Provider Group to non-payable in accordance with Section 10.5.

8.2. If the Quality Management Committee or Fraud, Waste, and Abuse Committee determines the Health Care Provider or Provider Group has not complied with the Corrective Action Plan, the Quality Management Committee, or Fraud, Waste, and Abuse Committee may take other disciplinary action proper and appropriate to the circumstances, which may include:

a. Notifying the Health Care Provider and Provider Group that the Corrective Action Plan will be continued for a specified period of time as determined by the Quality Management Committee or Fraud, Waste, and Abuse Committee and not to exceed an additional six (6) months, after which the case would be reviewed again.
   i. A Corrective Action Plan cannot exceed twelve (12) months.
   ii. At the completion of the twelve (12) month time frame, a final decision will be made, which may include:
      1. Discontinuation of the Corrective Action Plan,
      2. Change to non-participation status or recommend non-payable status, or
      3. Creation of a new Corrective Action Plan based upon findings of new concerns not addressed in the original Corrective Action Plan.

b. Notifying the Health Care Provider and Provider Group that the Corrective Action Plan is modified. The notice will include an updated description, associated activities and timelines.

c. Changing the Health Care Provider or Provider Group's status from participating to non-participating.

d. Making a recommendation to the Quality Committee of the Board to change the Health Care Provider or Provider Group's status from participating to non-payable.

9. PARTICIPATION STATUS ACTIONS

9.1. If the Quality Management Committee or Fraud, Waste, and Abuse Committee change the Health Care Provider or Provider Group's status to non-participating, the Health Care Provider and Provider Group will be notified in writing of the decision within ten (10) business days of the determination. The Health Care Provider or Provider Group will have ten (10) business days from the date of the notice to appeal the decision by submitting a written statement of his or her position to the requesting committee as designated in their communication.

9.2. If no appeal is received:

- BCBSND shall notify Members who are or have been under the care of the participating Health Care Provider within the past eighteen (18) months within forty-five (45) days of the determination.

- An Inter-Plan Program “Network Alert” (contract cancellation option), notifying other affiliated Blue Cross Blue Shield Association Plans of the status change, as required by the BlueCard® Program will be issued.

- The Quality Management Committee shall notify Quality Committee of the Board of its decision through the Quality Management Committee’s meeting minutes. The Fraud, Waste, and Abuse Committee shall notify the Quality Committee of the Board of the decision through the Fraud, Waste, and Abuse Committee’s meeting minutes.

9.3. If an appeal is received:

- a minimum of two (2) members of the Quality Management Committee and/or Fraud, Waste, and Abuse Committee not involved in the initial decision as reflected through the meeting minutes, along with a representative Health Care Provider, will consider the appeal. If two (2) uninvolved BCBSND members cannot be identified, ad-hoc members manager level or above may be selected by the chair of the respective committee. This first-level appeal panel may uphold the decision or provide a recommendation to reconsider the decision to the appropriate committee. The Health Care Provider nor Provider Group shall not have the right to participate in the deliberations.

    - If the decision is upheld or if the requesting committee reconsiders and elects to proceed with the status change the provider will be notified within ten (10) business days of the determination and a second-level appeal meeting will be scheduled in accordance with Section 9.4.

9.4. A meeting of the Quality Committee of the Board shall be scheduled. The Health Care Provider and Provider Group will be given at least ten (10) business day's written notice that the designated committee of the Board shall meet to discuss the appeal. The letter shall inform the Health Care Provider and Provider Group:

a. Of their right to be present at that meeting;

b. Of their right to present any additional information on their behalf;

c. Of the deadline and process for submission of any additional materials to be submitted to the designated committee of the Board for review prior to the meeting;

d. That a representative Health Care Provider will be selected to be present;

e. That visual or audio recording of the meeting is prohibited; and

f. Of any adjustments to the effective date of the change in status based on the scheduled date of the meeting.

BCBSND shall notify Members who are or have been under the care of the participating Health Care Provider or Provider Group within the past eighteen (18) months using the effective date as defined by the appeal meeting date. An Inter-Plan Program "Network Alert" (contract cancellation option), notifying other affiliated Blue Cross Blue Shield Association Plans of the status change, as required by the BlueCard® Program will be issued with the effective date.

The Quality Committee of the Board must report its findings to the Board of Directors and shall notify the Health Care Provider and Provider Group in writing of its decision within ten (10) business days of the meeting.

9.5. If the Health Care Provider or Provider Group's status is changed to non-participating as a result of a Corrective Action Plan, or if a non-participating provider was notified of their noncompliance with performance standards, the Quality Management Committee or Fraud, Waste and Abuse Committee will continue to monitor the Health Care Provider or Provider Group for a period of time as determined by the Quality Management Committee or Fraud, Waste, and Abuse Committee, not to exceed six (6) months. If the Committee finds that the Health Care Provider or Provider Group continues to be out of compliance with the performance standards required of a non-participating Health Care Provider, they shall notify the Health Care Provider and Provider Group in writing of their intention to submit a request to the Quality Committee of the Board to recommend a change of the Health Care Provider or Provider Group's status to non-payable.

The Health Care Provider may appeal by submitting a written statement of his or her position to the requesting committee within ten (10) business days of receipt of the notification. A minimum of two members of the Quality Management Committee and/or Fraud, Waste, and Abuse committee not involved in the decision to make the request as reflected through meeting minutes, along with a representative Health Care Provider, will consider the appeal. If two uninvolved BCBSND members cannot be identified, ad-hoc members, manager level or above, may be selected by the chair of the respective committee. This first-level appeal panel may uphold the request or provide a recommendation to reconsider the request to the requesting committee. The Health Care Provider nor Provider Group shall not have the right to participate in the deliberations.

If the decision is upheld or if the Quality Management Committee or Fraud, Waste, and Abuse Committee reconsider and determine the request for non- payable status is still appropriate, the request for change to non-payable status shall be completed in accordance with Section 10.6.

9.6. If the Quality Management Committee or Fraud, Waste, and Abuse Committee determines it is appropriate to submit a request to the Quality Committee of the Board to recommend changing a Health Care Provider or Provider Group's status to non-payable, the requesting committee shall notify the Health Care Provider and Provider Group in writing of their intention to submit a request to the Quality Committee of the Board to recommend a change of the Health Care Provider or Provider Group's status to non-payable.

The Health Care Provider or Provider Group may appeal this status change request by submitting a written statement of his or her position to the requesting committee within ten (10) business days of date of the notification. A minimum of two (2) members of the Quality Management Committee and/or Fraud, Waste, and Abuse committee not involved in the decision to make the request as reflected through meeting minutes, along with a representative Health Care Provider, will consider the appeal. If two (2) uninvolved BCBSND members cannot be identified, ad-hoc members, manager level or above, may be selected by the chair of the requesting committee. This first-level appeal panel may uphold the request or provide a recommendation to reconsider the request to the requesting committee. The Health Care Provider nor Provider Group shall not have the right to participate in the deliberations.

If the appeal is upheld or if the Quality Management Committee or Fraud, Waste, and Abuse Committee reconsider and determine the request for change to non-payable status is still appropriate, the Health Care Provider and Provider Group shall be notified within ten (10) business days of the decision and the request for change to non-payable status shall be completed in accordance with Section 10.6.

9.7. A meeting shall be scheduled to consider the matter. The Health Care Provider and Provider Group will receive at least ten (10) business days written notice that the Quality Committee of the Board shall meet to discuss the recommendation. This meeting serves as the final opportunity for the Health Care Provider or Provider Group to appeal. The letter will inform the Health Care Provider and Provider Group:

a. Of their right to be present at that meeting;

b. Of their right to present any additional information on their behalf;

c. Of the deadline and process for submission of any materials to be submitted to the designated committee of the Board for review prior to the meeting;

d. That a representative Health Care Provider will be selected to be present; and

e. That visual or audio recording of the meeting is prohibited.

If the Quality Committee of the Board finds that the Health Care Provider or Provider Group continues to be out of compliance with the performance standards required of a participating Health Care Provider, they may recommend to the Board of Directors that the Health Care Provider or Provider Group's status be changed to non-payable.

9.8. **Confirmation of Recommendation**: A recommendation to change the Health Care Provider or Provider Group's status to non-payable will be submitted by the Quality Committee board chair to the Board of Directors for consideration during its next regularly scheduled meeting, unless the Board calls a special meeting to consider that report. The Board may accept, modify or reverse the Quality Committee of the Board's recommendation, at its discretion. The Health Care Provider nor Provider Group shall not have the right to appeal or to otherwise participate in the Board's deliberations concerning the recommendation. Within ten (10) business days after the date of that meeting, the Board shall notify the Health Care Provider and Provider Group of its determination in writing, that this is the final decision and that all avenues of appeal have been exhausted. If the Health Care Provider or Provider Group continues to disagree with the determination, he/she may pursue normal remedies of law, if any.

If the Health Care Provider or Provider Group's status is changed to non-payable, BCBSND shall notify Members who are or have been under the care of the Health Care Provider or Provider Group within the past eighteen (18) months within forty-five (45) days of the determination.

All Health Care Providers or Provider Groups whose status is changed to non-payable shall be reported to the North Dakota Department of Insurance.

An Inter-Plan Program "Network Alert" (contract cancellation option), notifying other affiliated Blue Cross Blue Shield Association Plans of the status change, will be made, as required by the BlueCard® Program.

10. IMMEDIATE ACTION

10.1. **Temporary Suspension.** The Quality Management Committee and Fraud, Waste, and Abuse Committee reserve the right to place the Health Care Provider or Provider Group under temporary suspension, immediately making the Health Care Provider or Provider Group non-participating, non-payable or ineligible under any of the following circumstances:

a. If the state agency responsible for licensing, registration, or certification suspends or restricts a Health Care Provider or Provider Group's license, registration or certification.

b. There is reason to believe that the Health Care Provider or Provider Group has knowingly, intentionally, or with reckless disregard violated BCBSND's rules and regulations.

c. There is reason to believe that the Health Care Provider or Provider Group's actions may result in imminent danger to a member's health or welfare. *

d. There is reason to believe that the Health Care Provider or Provider Group's actions will impair BCBSND's reputation or operations.

The Quality Management Committee or Fraud, Waste, and Abuse Committee as appropriate shall notify the Health Care Provider and Provider Group in writing of the temporary suspension of the Health Care Provider or Provider Group's participation or status as payable.

*Any Medical Director has the authority to immediately issue this action through an ad hoc meeting of the Quality Management Committee without the need of a quorum.

10.2. **Confirmation of Suspension.** If the Quality Management Committee or Special Investigations

Unit and Provider Audit requires additional time to investigate allegations, the temporary suspension shall remain in effect pending the completion of that investigation. Such investigation must be completed within ten (10) business days after the imposition of the temporary suspension. The Quality Management Committee or Special Investigations Unit and Provider Audit shall notify the Health Care Provider and Provider Group of the results of the investigation and any further action to be taken.

10.3. The Quality Management Committee or Fraud, Waste, and Abuse Committee will present results of the investigation to the Quality Committee of the Board for final determination:

a. The Health Care Provider or Provider Group's temporary suspension is lifted.

b. The Health Care Provider or Provider Group is designated non-participating, non-payable, or ineligible.

10.4. If the Quality Committee of the Board changes the Health Care Provider or Provider Group's status to non-participating, the Health Care Provider and Provider Group will be notified in writing of the decision within ten (10) business days. The Health Care Provider or Provider Group will have ten (10) business days from the date of the notice to appeal the decision by submitting a written statement of his or her position to the committee of the Board as designated in their communication.

- BCBSND shall notify Members who are or have been under the care of the non-participating Health Care Provider or Provider Group within the past eighteen (18) months within forty-five (45) days of the determination.

- An Inter-Plan Program "Network Alert" (contract cancellation option), notifying other affiliated Blue Cross Blue Shield Plans of the status change, as required by the BlueCard® Program will be issued.

10.5. If an appeal is received, a meeting of the Quality Committee of the Board shall be scheduled. The Health Care Provider will be given at least ten (10) business day's written notice that the designated committee of the Board shall meet to discuss the appeal. The letter shall inform the Health Care Provider and Provider Group:

a. Of their right to be present at that meeting;

b. Of their right to present any additional information on their behalf;

c. Of the deadline and process for submission of any materials to be submitted to the designated committee of the Board for review prior to the meeting;

d. That a representative Health Care Provider will be selected in compliance with Section 8.3 to be present;

e. That visual or audio recording of the meeting is prohibited; and

f. Of any adjustments to the effective date of the change in status based on the scheduled date of the meeting.

The Quality Committee of the Board must report its findings to the Board of Directors and shall notify the Health Care Provider and Provider Group in writing of its decision within ten (10) business days of the meeting.

If the Health Care Provider or Provider Group's status is changed to non-participating, the Quality Management Committee or Special Investigations Unit and Provider Audit will continue to monitor the Health Care Provider and/or Provider Group under the terms of Section 10.4.

10.6. If the Quality Committee of the Board determines it is appropriate to make a recommendation to their respective Board committee to change a Health Care Provider or Provider Group's status to non-payable, a meeting shall be scheduled to consider the matter. The Health Care Provider will receive at least ten (10) business days written notice that the designated committee of the Board shall meet to discuss the recommendation. The letter will inform the Health Care Provider and Provider Group:

a. Of their right to be present at that meeting;

b. Of their right to present any additional information on their behalf;

c. Of the deadline and process for submission of any materials to be submitted to the designated committee of the Board for review prior to the meeting;

d. That a representative Health Care Provider will be selected in compliance with Section 8.3 to be present; and

e. That visual or audio recording of the meeting is prohibited.

If the Quality Committee of the Board finds that the Health Care Provider or Provider Group is out of compliance with the performance standards required of a participating Health Care Provider, they may recommend to the Board of Directors that the Health Care Provider or Provider Group's status be changed to non-payable.

A recommendation to change the Health Care Provider or Provider Group's status to non-payable will be submitted in compliance with Section 10.7.

10.7. **Request for Immediate Action**. The Quality Management Committee and Fraud, Waste, and Abuse Committee also reserve the right to request that the Board take immediate action regarding a Health Care Provider or Provider Group's participation status. This may be used as an alternative to the Temporary Suspension.

The Quality Management Committee or Fraud, Waste, and Abuse Committee as appropriate shall notify the Health Care Provider and Provider Group in writing of their intention to request immediate action from the Board committee.

The notification may also

a. Identify the Health Care Provider(s) or Provider Group involved

b. Provide a description of the complaint or violation.

c. Offer a description of the investigation process.

d. Give specific requirements to be followed by the provider during from the period of notification until the Board takes action such as:

- Counseling the Health Care Provider(s) and Provider Group concerning specific actions that should be taken to address identified problems
- Including claim submission requirements
- Mandatory prior authorizations for specified treatments or services
- Continuing education

- Closure of the Health Care Provider and Provider Group's practice to new members
- Any other actions deemed appropriate

The Health Care Provider or Provider Group may appeal by submitting a written statement of his or her position to the requesting committee within ten (10) business days of date of the notification. A minimum of two (2) members of the Quality Management Committee and/or Fraud, Waste, and Abuse committee not involved in the decision to make the request as reflected through meeting minutes, along with a Representative Health Care Provider selected in compliance with Section 8.3, will consider the appeal. If two (2) uninvolved BCBSND members cannot be identified, ad-hoc members manager level or above may be selected by the chair of the respective committee. This first-level appeal panel may uphold the request or provide a recommendation to reconsider the request to the requesting committee. The Health Care Provider nor Provider Group shall not have the right to participate in the deliberations.

If the appeal is upheld or if the Quality Management Committee or Fraud, Waste, and Abuse Committee reconsider and determine the request for immediate action is still appropriate, the Health Care Provider and Provider Group shall be notified within twenty (20) business days of receipt of the appeal and the request shall be completed in accordance with Section 11.8.

10.8. A meeting shall be scheduled to consider the matter. The Health Care Provider and Provider Group will receive at least ten (10) business days written notice that the designated committee of the Board shall meet to discuss the request for immediate action. This meeting serves as the final opportunity for the Health Care Provider or Provider Group to appeal. Notification will be sent informing the Health Care Provider and Provider Group:

a. Of their right to be present at that meeting;

b. Of their right to present any additional information on their behalf;

c. Of the deadline and process for submission of any materials to be submitted to the designated committee of the Board for review prior to the meeting;

d. That a representative Health Care Provider who is not a member of the Board and who is of the same specialty as the Health Care Provider under investigation shall be present in an advisory capacity only. The Quality Management Committee or Fraud, Waste and Abuse Committee will arrange for this representative to be present; and

e. That visual or audio recording of the meeting is prohibited.

The designated Board Committee will make one of the following determinations:

f. Deny the request for immediate action
    - Any temporary requirements are eliminated

g. Implement a CAP for a period of time not to exceed 6 months
    - This will be completed in accordance with Section 7, without the opportunity for appeal

h. Recommend the Health Care Provider or Provider Group’s status be changed to non-participating
    - This is completed in accordance with Section 10.3 without the opportunity for appeal

i. Recommend the Health Care Provider or Provider Group's status be changed to non-payable
    - This will be completed in accordance with Section 10.7 without the opportunity for appeal

11. REAPPLICATION FOR PARTICIPATION STATUS

11.1. **Non-Participating Provider or Provider Group**: A Health Care Provider or Provider Group whose status was changed to non-participating through this policy shall have the right to reapply for participation status no less than eighteen (18) months after the date their status was changed to non-participating. The Health Care Provider or Provider Group must meet all credentialing requirements and submit sufficient written evidence that the original concerns of the Quality Management Committee or Fraud, Waste and Abuse Committee have been remedied.

11.2. **Non-Payable Provider or Provider Group**: A Health Care Provider whose status was changed to non-payable through this policy shall have the right to seek review of the non-payable status no less than thirty-six (36) months after the date their status was changed to non-payable. The Health Care Provider must meet all credentialing requirements and submit sufficient written evidence that the original concerns of the Quality Management Committee or Fraud, Waste and Abuse Committee have been remedied.

11.3. **Reinstatement Plan:** The Health Care Provider or Provider Group must re-apply for participation status through the standard credentialing process. If all credentialing requirements are met, the Health Care Provider or Provider Group shall be granted participation status subject to a Reinstatement Plan. The Health Care Provider or Provider Group will be provided with:

a. A description of the Reinstatement Plan, including associated activities and timelines, which may include, but is not limited to:

    - Counseling the Health Care Provider(s) or Provider Group concerning additional specific actions that should be taken to address previously identified problems not addressed through the documentation supplied
    - Claim submission requirements
    - Mandatory prior authorizations for specified treatments or services
    - Continuing education
    - Regular audits
    - Any other actions deemed appropriate

b. A list of the activities the Quality Management Committee or Fraud, Waste and Abuse Committee will use to monitor compliance and effectiveness of the implemented corrections.

c. A statement that the Health Care Provider or Provider Group will be reviewed for no less than six (6) months from reinstatement of participation.

Results of compliance with the Reinstatement Plan will be reported to the Quality Committee of the Board.

Costs associated with the increased review time by BCBSND shall be the responsibility of the provider seeking full participation status. The expected costs and timeline will be communicated to the Health Care Provider and Provider Group as part of the Reinstatement Plan.

12. CONFIDENTIALITY AND REPORTING REQUIREMENTS

Records or information concerning the activities of the Quality Committee of the Board, the Quality Management Committee, the Special Investigations Unit and Provider Audit and/or the Fraud, Waste and Abuse Committee shall be treated and maintained as privileged and confidential records to the fullest extent permitted by state and federal laws. Reports to the committees, the Board of Directors or regulatory agencies concerning actions taken pursuant to this policy shall not alter the status of such records or information as privileged and confidential information.

This policy is reviewed and approved annually by the internal and Board Committees referenced herein.