Disciplinary Action & Practitioner Appeal Policy

1. Purpose

This policy will define and describe the disciplinary action process, the Practitioner Appeal process, and the process of reporting serious quality deficiencies, as required, to appropriate authorities.

2. Policy

It is Priority Health's policy to allow practitioners who are affiliated with Priority Health and/or its subsidiaries (collectively referred to as "Priority Health") to purse an appeal under certain circumstances when Priority Health proposes to deny, restrict, reduce, or terminate affiliation based on an adverse finding of a professional review activity.

A practitioner's affiliation with Priority Health may be subject to denial, restriction, reduction, alteration, or termination for quality concerns or administrative issues (administrative issues are non-quality concerns) based on the competence or professional conduct of a practitioner which affects or could adversely affect the health or welfare of a patient or patients. In the event a practitioner has been terminated from the Priority Health network, member reassignment may have already occurred during the standard termination process and prior to the practitioner's appeal.

A **Quality concern** is defined as an adverse action that is/was an internal-to-Priority Health quality concern or other event that is/was attributed to a Priority Health member. Quality concerns may only be attributed to a currently participating provider, regardless of product participation. Quality concerns that could trigger an adverse action under this policy include, but are not limited to, internal evidence of substandard treatment rendered to Priority Health members, Priority Health member complaints/grievances related to quality concerns, and malpractice judgments/settlements related to a Priority Health member. Prior to taking any formal final action to deny, restrict, reduce, or terminate affiliation based on quality concerns, the practitioner is allowed to pursue the appeal process as described herein. All currently participating providers, regardless of product participation, are eligible to request a hearing to appeal against an adverse action based on a quality concern.

An **Administrative issue** is defined as an adverse action that is/was an external-to-Priority Health event that is/was not attributed to a Priority Health member. Administrative issues can be attributed to a non-participating provider seeking participation (initial credentialing) or a currently participating provider seeking continued participation (recredentialing). Administrative issues include Credentialing Committee review of past issues and events that were external to Priority Health and not attributed to a Priority Health member. Administrative issues (which are considered non-quality concerns) that could trigger an adverse action under this policy include, but are not limited to, incomplete application or failure to meet any Acceptance/Continued Participation Criteria. Such circumstances are straightforward and do not contain an inherent aspect of judgment on which a substantive Quality concern could normally be based. Nevertheless, should the practitioner have the evidence to the contrary, the practitioner is allowed to pursue the appeal process as described herein, for purposes of a Medicare contract only. Only currently participating providers holding a Medicare contract with Priority Health are eligible to request a hearing to appeal against an adverse action based on an administrative issue.

A. Corrective Action Prior To Proposing Change in Affiliation Status or Privileges

Prior to proposing a change in affiliation status for a participating provider due to a quality concern, Priority Health will attempt to effect improvements in the practitioner's performance through corrective action including but not limited to, interventions and discussions with the practitioner by the CMO, Associate Medical Directors, and/or the Credentialing Committee; changes in practice; recommendations for CME or other education, as appropriate and/or indicated. This corrective action only pertains to participating providers facing an adverse action based on a quality concern (i.e. the reason is/was internal to Priority Health).

Prior to proposing a change in affiliation status for a participating provider due to an administrative issue, Priority Health will afford the provider an opportunity for a Reconsideration Request in order for the provider to submit any additional information that the Credentialing Committee has not previously reviewed. Reconsideration request submissions are limited to 30 days and will occur prior to the execution of the Practitioner Appeal Process. This corrective action only pertains to participating providers facing an adverse action based on an administrative issue (i.e. the reason is/was external to Priority Health).

B. Practitioner Appeal Process

1. Except as otherwise specified herein, if the Credentialing Committee recommends that a participating practitioner's affiliation with Priority Health be denied, restricted, reduced, altered, or terminated, Priority Health will grant the practitioner the right to a hearing in order to resolve matters bearing on professional competence and/or conduct in accordance with the following procedure. Priority Health will conduct the hearing according to all procedural safeguards set forth below.

    - If Priority Health is not obligated to offer a hearing to participating practitioners without a Medicare contract who are terminated based on an Administrative issue.

    - If Priority Health terminates the Medicare contract of a participating practitioner for *any* reason (quality concern or administrative issue), the practitioner will be afforded the opportunity to a hearing in accordance with this policy.

2. The practitioner will exhaust all hearing procedures afforded in this procedure before resorting to any legal action against Priority Health on either procedural or substantive grounds. If the practitioner takes legal action before exhausting all hearing procedures afforded in this procedure, the practitioner will be deemed to have waived all rights to a hearing and if the practitioner does not prevail in such action, the practitioner will bear the legal costs, including reasonable attorney's fees, incurred by Priority Health, in defending the legal action.

3. The initial recommendation to take an adverse action (i.e., denial, restriction, reduction, alteration, or termination) for quality concerns are made by the Credentialing Committee, or if necessary, in urgent situations, the CMO or his/her designee.

4. If the Credentialing Committee recommends an adverse action be taken against the participating practitioner for quality concerns or administrative issues, the Credentialing Committee will notify the practitioner, in writing, of its recommendation within fifteen (15) days of its decision by electronic and/or certified mail. The notice shall:

    a. state the recommendation;

    b. present the Credentialing Committee's reasons for the recommendation, including the acts or omissions attributed to the practitioner;

c. state that the practitioner has the right to request a hearing on the recommendation (and that if the hearing is not requested within this time frame that the practitioner is deemed to have waived his/her right to any appeal);

d. state that the practitioner has 30 days within which to make a written request for a hearing; and

e. summarize the hearing process and the practitioner's rights as they relate to the hearing, including who presides over the hearing, how the hearing will be conducted, the practitioner's right to representation, the practitioner's right to receive a written recommendation and opinion after the hearing, and the forfeiture of the practitioner's right to a hearing if the practitioner fails, without good cause, to appear at the hearing.

5. If the practitioner does not request a review within the thirty (30)-day time period (of electronic and/or certified mail), the practitioner is deemed to have waived his/her appeal rights and appropriate steps are taken to deny, restrict, reduce, alter, or terminate the practitioner's affiliation, in accordance with the notice and other provision of any applicable provider contract(s). Additionally, Priority Health will report the final action to the appropriate regulatory authorities, including the state licensing entity and the National Practitioner Data Bank (NPDB) pursuant to Section C below. If a practitioner voluntarily restricts or terminates affiliation, while under investigation, or offers to alter affiliation, in return for not conducting an investigation, Priority Health will report to the appropriate authorities, including the NPDB.

6. If the practitioner requests a hearing within the (30) day period – and/or - if the practitioner submits additional information with the hearing request that was not previously reviewed by the Credentialing Committee, the additional information will be submitted as a Reconsideration Request (see item 2.A, second paragraph) for Credentialing Committee review, prior to the execution of the hearing request.

7. If the practitioner requests a hearing within the (30) day period, the Credentialing Committee will give the practitioner written notice, via electronic and/or certified mail, of the hearing date. The date of the hearing will be scheduled for a date that is at least 30 days after the date of the written notice from Priority Health (see sample notice attached to this policy). The notice will state:

    a. the place, time and date of the hearing; and

    b. the names of any witnesses expected to testify at the hearing on behalf of Priority Health or Managed Benefits.

    c. a statement that if the practitioner fails to appear at the review without good cause, h/she will forfeit the right to the review.

8. Following receipt of the written notice from Priority Health referenced in paragraph #6 above, the practitioner shall have fifteen (15) days from hearing date notice to confirm, in writing (by electronic and/or certified mail), acceptance of the established hearing and identify any attorney or other representative the practitioner will bring to the hearing. If the practitioner does not confirm acceptance of the established hearing within the time frame ((15) days from the hearing date notice) and in the manner described above or fails to appear at a scheduled hearing, the practitioner shall be deemed to have waived any right to a hearing and to have accepted the recommendation. Such a recommendation shall then become the final action of the Credentialing Committee.

9. Within fifteen (15) days of being notified of a practitioner's intent to use the appeal process, pursuant to Section B.4.d, the CMO or his/her designee shall name not less than three (3) nor more than seven (7) in-plan practitioners to serve on the Appeal Committee, which is the body to review practitioner appeals. The Appeal Committee members shall have the appropriate expertise, qualifications, and experience to address the issues raised in the appeal. Such practitioners will be "peers" of the appealing practitioner, i.e., appropriately licensed and trained practitioners in a practice similar to the appealing practitioner. The Appeal Committee members shall not be members of the Credentialing Committee unless such member was absent during the Credentialing Committee meeting that made the recommendation to take the adverse action against the practitioner.

10. Practitioners appointed to the Appeal Committee shall not be in direct economic competition with the appealing practitioner. For purposes of this procedure, a practitioner in direct economic competition shall mean that the practitioner will be directly affected economically by the outcome of the appeal. If any practitioner member of the Appeal Committee is in direct economic competition with the appealing practitioner, such practitioner shall not participate in the review process. Each practitioner member who participates in the review process is asked to sign a statement indicating that it is his/her belief that s/he is not in direct economic competition with the appealing practitioner.

11. In appointing the Appeal Committee, the CMO shall designate one member as chair of the Appeal Committee. The Chair of the Appeal Committee shall be the presiding officer at the appeal and shall be responsible for conducting the appeal consistent with this Policy. The Chair will rule on all procedural issues so as to conduct a fair process. The Chair shall be entitled to vote on all matters before the Appeal Committee.

    a. The appealing practitioner has the right to inquire about which practitioners are seated on the Appeal Committee up to 14 days prior to the Appeal. The CMO, or his/her designee, may elect to change the composition of the Appeal Committee upon the appealing practitioners' objections to any named Appeal Committee member based upon clear and convincing proof of direct economic competition with the appealing practitioner. In his/her discretion, the CMO or his/her designee may elect to change the composition of the Appeal Committee upon the appealing practitioner's objection. The CMO of his/her designee shall remove any member of the Appeal Committee upon clear and convincing proof of direct economic competition with the appealing practitioner.

12. The rules of procedure for the hearing will be as follows:

    a. The CMO or his/her designee will be responsible for presenting the basis of the adverse determination.

    b. The appealing practitioner will be given the opportunity to state his/her position.

    c. Each of the parties has the right to present written material or other evidence relevant to the matter at issue, as well as to submit a written summary of their position.

    d. The appealing practitioner shall be entitled to be represented by an attorney or any other person of the practitioner's choice at the hearing.

    e. The appealing practitioner shall bear the burden of proof to show that the intended adverse action was arbitrary, unreasonable or capricious by a preponderance of the evidence.

f. The appealing practitioner may call witnesses on his/her behalf and/or cross-examine other witnesses.

g. The appealing practitioner may present evidence determined to be relevant by the Appeal Committee, regardless of its admissibility in a court of law.

h. The appealing practitioner may submit a written statement at the close of the hearing.

i. A quorum shall be a majority of the appointed Appeal Committee members. A recommendation by the Appeal Committee must be supported by a majority of those members in attendance.

j. The Rules of Evidence shall not apply to the appeal process. The Appeal Committee shall consider all evidence relevant to the adverse determination.

k. Postponement shall only be granted by the Chair upon good cause shown.

l. The members of the Appeal Committee shall vote to make a recommendation concerning the practitioner. The CMO or his/her designee has no vote.

m. Minutes of the appeal shall be taken in sufficient detail to document the proceedings and decisions. Written submission shall become part of the appeal record. The appealing practitioner may request a copy of the minutes of the appeal and any written submissions. Transcripts of the appeal shall not be made.

n. Within 45 days of completion of the hearing, the Chair of the Appeals Committee will provide the Credentialing Committee a written recommendation regarding whether the Credentialing Committee should allow the practitioner to retain network membership rights or whether the Credentialing Committee should suspend or revoke such rights. The report shall include a statement of the basis for the conclusion.

o. The Credentialing Committee shall make the final decision and within 10 days shall send to the practitioner its written, final decision, including the recommendation of the Appeals Committee, and a statement of the basis for that decision. This action will then be reported to the Medical Affairs Committee.

13. If the final decision is such that a report is required to be made to the National Practitioner Data Bank (NPDB), Priority Health will comply using the procedures outlined in the NPDB Guidebook~~s~~.

14. If, due to its final decision, a state law or regulation requires Priority Health to report its action to a State agency, Priority Health will notify the designated authority in accordance with the specifications of the applicable State law or regulation.

C. Process for Reporting to Appropriate Authorities

It is the policy of Priority Health to comply with all federal and state statutes and regulations regarding the reporting of adverse professional review actions.

If the final corrective action is such that a report is required to be made to the National Practitioner Data Bank (NPDB) Priority Health will comply using the procedures outlined in the National Practitioner Data Bank Guidebook and official NPDB website at http://www.npdb.hrsa.gov. The Credentialing department (in conjunction with Priority Health legal

counsel) is responsible for submitting any adverse action report to the NPDB electronically via the Integrated Querying and Reporting Service (IQRS) at https//npdb.hrsa.gov.

If, due to Priority Health's final decision, a state law or regulation requires Priority Health to report its action to a State agency, Credentialing will notify Priority Health's Legal and Special Investigation Unit (SIU) departments who will notify the designated authority in accordance with the specifications of the applicable State law or regulation. The Special Investigation Unit (SIU) department (in conjunction with Priority Health legal counsel) is responsible for submitting any adverse action report to the applicable states.

Any action resulting in a termination of a Medicaid contract will be reported on the Network Provider Adverse Action Reporting form and sent to the Manager of the Special Investigation Unit (SIU) who will then report to the appropriate state or regulatory agencies.

All results are documented in the provider data management systems.

3. Revisions

3/93, 5/5/99; 8/4/99, 11/3/99, 12/6/00, 8/1/01, 9/02, 10/03, 4/14/04, 11/3/04, 3/2/05, 2/1/06, 3/4/09, 12/7/11, 4/11/14, 8/14/19, 1/2024, 7/1/2025, 7/24/25, 8/5/2026

Priority Health reserves the right to alter, amend, modify or eliminate this policy at any time without prior written notice.

Policies Superseded and Replaced: Formerly part of Policy #2/0030/R3 – Practitioner Credentialing, Recredentialing and Hearing Policy & Procedure.

4. References

NCQA CR Standards

<<DATE>>

PERSONAL & CONFIDENTIAL

CERTIFIED MAIL

<<PRAC NAME>> <<PRAC TITLE>>
<<PRAC LOCATION NAME>>
C/O <<PRAC CONTRACTED GROUP NAME>>
<<ADDRESS>>
<<CITY>> <<STATE>> <<ZIP>>

Dear **<<PREFIX>>. <<PRAC LN>>**:

This letter is to notify you that the following date, time, and place have been selected for the hearing you requested regarding your termination from the Priority Health Medicare network:

Date: **<<DATE>>**
Time: **<<TIME>>**
Place: **<<PLACE OR MICROSOFT TEAMS MTG LINK>>**

Per the Disciplinary Action & Practitioner Appeal Policy (attached), you have fifteen (15) days following receipt of this notification in which to confirm, in writing (by certified mail), acceptance of this hearing date. You are also required to identify any attorney or other representative who will be attending the hearing with you. If you do not confirm acceptance of this hearing date within the time frame and in the manner described above or if you fail to appear at the scheduled hearing, you will waive any right to a hearing and accept the recommendation.

The following individuals are expected to testify at the hearing on behalf of Priority Health.

- Name and title (Medical Director)
- Name and title
- Name and title

Please send your response to my attention at the following address:

Name and title, Vice President, Medical and Clinical Operations
Priority Health
1231 East Beltline NE
Grand Rapids MI 49525

Sincerely,

PRIORITY HEALTH

Vice President, Medical & Clinical Operations

cc:

Enclosures: Disciplinary Action & Practitioner Appeal Policy

SAMPLE