# HNS
# Credentialing Policies
# for Physicians



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# I. Definitions

*Applicant*

A doctor of chiropractic who has submitted an application to HNS for credentialing or re-credentialing.

*Client*

A health care entity with which HNS contracts and which has delegated to HNS various intermediary functions including credentialing of health care providers who will provide services to their members.

*Credentialing*

A part of the HNS Continuous Quality Improvement Program, which verifies credentials with the issuer of the credential or other recognized monitoring organization in order to evaluate a provider's qualifications and competency.

*Credentialing Committee and Hearing Panel*

Committees to which the HNS Board of Directors has delegated responsibility to make all final decisions regarding participation in the HNS network.

*Credentialing Specialist*

HNS employee who is responsible for carrying out the verification process: tracking, updating, reporting, and gathering of information pertaining to the HNS Credentialing Program.

*Complete Application*

An application for which 1) all blanks on the application form are filled in and necessary additional explanations provided; 2) all requested attachments have been submitted; 3) verification of the information is complete; and 4) all information necessary to properly evaluate the applicant's qualifications has been received and is consistent with all other information provided in the application.

*Complete File*

A complete file is a file that includes a complete application, a signed Attestation Statement/Authorization Statement, and all information necessary to properly evaluate the applicant's qualifications.

*Delegated Credentialing Agreement*

A mutually agreed upon contract, memorandum of understanding, letter of intent or other document by which a client delegates specified credentialing responsibilities to HNS and requires HNS to meet certain standards related to its credentialing and re-credentialing responsibilities.

*Designee*

An appropriately qualified physician, if the reference is to "Medical Director or his/her designee." If the reference is to one other than the Medical Director, then Designee means another appropriately qualified individual.

*Independent Relationship*

An independent relationship exists between HNS and a provider when HNS has an executed Practitioner's Participation Agreement with the provider.

*Initial Credentialing*

The process through which HNS collects, reviews, verifies, and evaluates specific criteria in order to approve or deny a provider's initial request for participation in the HNS Network.

*Member*

A person enrolled in a health care program. HNS has the responsibility to provide certain administrative services to members as specified in delegation agreements with clients.

*National Providers Data Bank (NPDB)*

An information clearinghouse established by Title IV of Public Law 99-660 (the Health Care Quality Improvement Act of 1986), to collect and release certain information related to the professional competence and conduct of physicians, dentists and other health care providers. The U.S. Government established the Data Bank to enhance professional review efforts by making certain information concerning medical malpractice payments and adverse actions available to eligible entities and individuals.

*National Committee for Quality Assurance* (*NCQA)*

A non-profit organization that promotes health care quality by accrediting health care organizations.

*Network*

Refers to the HNS network of providers contracted to provide services to members of HNS clients.

*Provider*

A doctor of chiropractic who is permitted by law to practice independently within the scope of his/her license or certification and who has, or seeks to have, an independent relationship with HNS in order to provide care to members of health care plans contracted with HNS.

*Primary Source Verification*

Refers to contacting the entity, agency or institution, which issues a provider's credential, for verification of authenticity of documents. For the purposes of this policy, primary source verification means contacting either the actual issuer or

another recognized monitoring source approved for verification by the National Committee for Quality Assurance (NCQA).

*Quality Complaints*

Complaints received from a member which alleges conduct that could adversely affect the health or well-being of a member or is otherwise inconsistent with HNS target criteria for approval and specifically includes complaints related to HNS access and practice site requirements.

*Quality Issues*

Any issues or complaints including sanctions, disciplinary action, restrictions or loss of license, malpractice claims history, criminal/civil convictions or exclusions/debarment from federal health care programs, which could adversely affect the health or well-being of a member, and includes issues relating to HNS Practice Site Requirements.

*Re-credentialing*

The process through which HNS collects, reviews, verifies, and evaluates specific criteria in order to approve or deny a provider's continued participation in the HNS Network.



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# II. Introduction

HNS is a clinically integrated physician network whose mission is to make health care more accessible, more effective and more affordable.

A clinically integrated network is a collection of health care providers who commit to work together on the quality and cost-effectiveness of a care for a specific population. While clinical integration tends to have many definitions, and is not a firm set of principles or practices. In simple terms, *clinical integration is a continuous process that supports the **triple aim of health care**:*

- Improving quality of care
- Reducing or controlling the cost of care
- Improving access to care and the overall patient experience

Through its Credentialing, Quality and Utilization (QUM) and other programs, HNS seeks to improve the quality, effectiveness and efficiency of the health care delivery system in our service area, and to help control the costs of that health care. These efforts create efficiencies for contracted managed care plans, their members or beneficiaries, as well as for its contracted health care practitioners.

HNS creates efficiencies in our service area by:

a. Establishing mechanisms to monitor and control utilization of health care services provided by its contracted health care professionals designed to control costs and ensure quality of care, and

b. Improving access to care in our service area, and

c. Selectively choosing, for initial and continued participation, physicians who are committed to the consistent delivery of safe, quality, and cost-effective health care.

d. Developing and maintaining policies and standards which promote quality, cost-efficiency, and improve the overall patient experience, and

e. Investing significant capital, both monetary and human, in its infrastructure, in order to achieve its efficiency objectives.

The objective of the HNS Credentialing Program is to evaluate the qualifications of providers who seek to provide care for members of health care plans contracted with HNS in order to maintain a network of qualified providers that meet and exceed member needs for quality, accessibility, effectiveness and safety.

The HNS credentialing and re-credentialing process is a systematic approach to the collection and verification of a provider's professional qualifications. With the exception

of provisional credentialing, the credentialing process must be completed before a provider is accepted for participation in the HNS Network.

The credentialing process incorporates three primary functions:

1. Initial credentialing to evaluate an individual's qualifications for participation in the network;

2. Re-credentialing to reassess qualifications for continued participation in the network; and,

3. On-going monitoring between credentialing cycles to ensure that providers continue to remain eligible for participation, which includes monitoring of licensure actions, Medicare/Medicaid sanctions (exclusion/debarment from federal health care programs), malpractice claims history, criminal/civil convictions, and complaints related to quality and/or to HNS Practice Site Standards.

# III. General Credentialing Policies

1. **Credentialing Policy**
   Participants will be credentialed and re-credentialed pursuant to the HNS Credentialing Plan and Policies and in accordance with NCQA standards, the terms of delegated credentialing agreements, and all applicable laws. HNS verifies that certain qualifications are met for providers before delivering care to members, at least every three years for participating providers, and on an ongoing basis for certain credentials.

   Participation in the HNS Network is not guaranteed and all applications and requests for participation and continued participation shall be evaluated in accordance with the HNS Credentialing Plan and Policies.

   HNS has the sole right to determine which physicians it will accept and maintain within its Network, and the terms on which it will allow participation.

   Neither this Credentialing Plan nor HNS Credentialing policies limit HNS's rights under the pertinent Practitioner's Participation Agreements that govern HNS's relationships with providers.

2. **Network Participation**
   The following requirements apply to all health care professionals who have chosen to participate in the HNS Network via execution of the HNS Practitioner's Participation Agreement:

   - Each HNS provider shall serve as an "in-network" provider for each applicable health care plan with which HNS contracts. *(*Providers cannot "opt out" of one or more plans with which HNS contracts.)

   - Participation in the HNS Network extends to any practice location the provider maintains in the HNS Service area. (Regardless of the number of practice locations or the location itself, the provider must be available to provide chiropractic care to any patient whose health care plan contracts with HNS, at each practice location, during all hours the practice is open for business.)

   - During participation in the HNS Network, providers may not close their practices to new patients whose health care plans contract with HNS.

   - To avoid confusion for members seeking chiropractic care from an "in-network" provider, all chiropractors practicing at the same physical location must participate in the HNS Network or none of the chiropractors practicing at that location may participate in the HNS Network. This includes but is not limited to chiropractors in a group practice, chiropractors renting space



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from another chiropractor and chiropractors practicing as independent contractors within another chiropractor's office.

- Health care plans with which HNS contracts have various requirements for participating "in-network" providers, such as maintaining current PTAN and/or Medicaid numbers. At all times, all HNS providers must meet all requirements set forth by all applicable contracted health care plans.

3. **Statutory and Regulatory Compliance**
HNS shall identify statutory and regulatory issues related to credentialing and re-credentialing, develop and implement procedures for compliance, and comply with all applicable laws.

4. **Agreement and Collaboration with Clients**
HNS conducts delegated credentialing activities in accordance with NCQA and URAC standards and the terms of client intermediary agreements, client delegated credentialing agreements and additional directives from the client. HNS shall collaborate with clients to ensure appropriate credentialing of providers in the HNS Network and provide clients with documents necessary for oversight. HNS shall maintain written delegation agreements between HNS and clients who have delegated credentialing to HNS.

5. **Annual Review of HNS Credentialing Plan**
HNS's Credentialing Plan and Policies are reviewed in its entirety at least annually by the Credentialing Committee.

6. **Modifications to HNS Credentialing Plan/Policies**
HNS has the right to change the Credentialing Plan and Policies at any time to meet regulatory requirements or for other organizational or business needs. Accordingly, policies posted on this website may not reflect changes made since these policies were last published.

   Any change in legal, regulatory or accreditation requirements will be automatically incorporated into this plan as of the requirement's effective date. Changes will be effective for all new and existing providers from the effective date of the change.

7. **Credentialing Fees**
HNS will not charge a credentialing fee for applicants wishing to join the HNS Network or for re-credentialing providers. HNS may charge a fee of $500.00 to providers who previously participated in the network, and reapply for participation.

8. **Status of Applicant after Credentialing Committee Decision Date**
Acceptance of an applicant into the HNS Network is conditioned upon the applicant's agreement to accept HNS's terms and conditions of participation as

attested to by the applicant's signature on the Practitioner's Participation Agreement. Indication that the applicant meets the credentialing criteria does not create a contract between the applicant and HNS.

While the applicant is considered a Participating Provider and is eligible to treat members as a participating provider as of the Credentialing Committee's decision date, the provider cannot submit claims for services provided to client's members until all demographic information has been entered into HNS and client information systems and until the Provider Orientation has been completed. HNS will notify providers, either via telephone, facsimile, or e-mail of the date on which he/she can begin submitting claims to HNS.

**9. Status of Applicant after the Client's Credentialing Committee**

Acceptance of an applicant into the HNS Network is conditional upon the applicant's approval by the client's credentialing committee. As referenced in the delegation agreement between HNS and the client, at all times the client reserves the right to approve, deny, or terminate participation for any provider. If the client notifies HNS that a provider has been denied participation, HNS must terminate the provider from the network and immediately inform the provider that he/she no longer meets HNS's credentialing requirements.

**10. Requests for Information Regarding Terminations**

Following denial or termination of participation from the network, requests from a provider for additional information relating to his/her denial or termination must be submitted in writing to HNS. HNS provides a written response to the provider's inquiry within 30 days of receipt of the written request.

# IV. Scope of Credentialing

**Purpose:**
To establish the scope of HNS's Credentialing Program and the types of providers to be credentialed by HNS

**Policy:**
HNS's Credentialing Program shall involve Doctors of Chiropractic (DCs) who have a contracted, independent relationship with HNS, or who are requesting such relationship with HNS, in order to provide services as a HNS participating provider to members of clients' health plans. The Program also involves DCs who serve in an administrative capacity for HNS.

An independent relationship exists between HNS and a provider when HNS has an executed Practitioner's Participation Agreement with the provider.

All providers participating in the HNS Network, or seeking participation in the network, will be subject to the credentialing policies and procedures outlined in the HNS Credentialing Plan and Policies.

If, during the credentialing process, HNS requests healthcare or other records which may be needed to determine if the provider meets HNS' credentialing criteria, the provider must comply with such requests, and must do so regardless of whether the care in question was provided to a patient whose healthcare plan contracts with HNS. (HIPAA *specifically permits use and disclosure of PHI for treatment, payment and healthcare operations (**TPO**) without the member's consent*, and this specifically includes disclosures related to credentialing activities.)


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# V. Provider Rights and Responsibilities

**Purpose:**
To establish the rights and responsibilities of providers requesting participation or re-appointment in the HNS Network

**Policy: Provider Rights**
The HNS Credentialing Program affords certain rights to providers applying for initial or continued participation in the HNS network, including the right to be notified of these rights.

Providers shall have the following rights and these rights shall, at all times, be posted on the HNS Website under the Credentialing section for Healthcare Professionals.

- To review information submitted to support their application to the extent permitted by law.
- To correct erroneous information
- To be informed, upon request, of the status of their application and HNS' process for responding to such requests.
- To receive notification of these rights
- To be notified of the credentialing decision
- To appeal certain adverse decisions

1. **To review information submitted to support their application**
   Providers may request a review of their files by notifying HNS, in writing, of the request. The provider may contact HNS, via email or facsimile, as follows:

   - Email: support@healthnetworksolutions.net
   - Fax: (877) 329-2620, Attn: Credentialing

   The reviewable information includes any information collected through the credentialing or re-credentialing process unless it is peer-review protected information or otherwise is prohibited by law. Reviews of credentialing files may only occur on the HNS premises and will take place at a mutually agreed upon time. The provider may not remove the file from the HNS premises. All reviews will be conducted in the presence of at least one HNS Credentialing Committee member.

2. **To update/correct information**
   HNS will contact a provider by telephone or writing regarding any information obtained during HNS's credentialing or re-credentialing process that varies substantially from the information provided to HNS by the provider. This includes, but is not limited to, substantial variations in information regarding


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licensure, malpractice claims history, and reports to government or authoritative agencies. HNS will notify the provider within 15 days of receipt of the information that is inconsistent with the information the provider submitted to HNS.

The provider may submit additional or corrective information, in writing, to HNS. The provider may submit information to HNS via email or facsimile, as follows:

- Email: support@healthnetworksolutions.net
- Fax: (877) 329-2620, Attn: Credentialing

HNS requires that all such information be initialed or signed by the provider; therefore, a staff member may not sign on behalf of the provider. HNS may require that such documents be notarized, if applicable. Such information must be sent to the attention of the HNS Credentialing Director or Credentialing Specialist, and must be received by HNS within 5 business days from the receipt of HNS's original notification of the discrepancy. The Credentialing Committee will consider any additional information submitted by the provider.

3. **To be informed, upon request, of the status of their application**
   Should a provider wish to know the status of his/her credentialing application, the provider may contact HNS, via or via facsimile, or e-mail.

   - Telephone: (877) 426-2411, ex,.118
   - Email: support@healthnetworksolutions.net
   - Fax: (877) 329-2620, Attn: Credentialing

   HNS will provide responses to requests for status of applications within 72 hours from receipt of the request. Responses to such requests may be given either via telephone, facsimile, e-mail, or written notification sent via U.S. Postal Service.

   When responding to such requests, HNS shall provide the physician with:

   - If requested, the date the application was received at HNS and

   - The actual status of the application on the date the inquiry was received.

   - If requested, the anticipated date that the application will be presented to the HNS Credentialing Committee for decision-making.

4. **To be notified of the credentialing decision**


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Providers have the right to receive written notification of HNS's credentialing decision within 10 days from the date the decision was rendered.

5. **Right to Appeal Certain Adverse Determinations**
   Providers have the right to appeal certain adverse determinations. If the decision is an appealable decision, the notification to the provider will include his right to appeal as well as information regarding the appeals process.

**Policy: Provider Responsibilities**
Provider applicants shall produce all information required by the application, required by NCQA and/or HNS contracted payors, or requested by HNS as permitted by law, in addition to the application. This information is needed for the proper evaluation of their qualifications including, but not limited to, licensure, malpractice insurance coverage and malpractice claims history, work history, competence, character, and for resolving any doubts about the providers' qualifications and professional integrity.
Participating providers are responsible for notifying HNS, in writing, no later than 15 calendar days following the occurrence of any of the following events:

1. Provider's license to practice in the state is suspended, revoked, terminated, or subject to terms of probation or other restrictions, or there are any subsequent changes in the status of any information relating to provider's professional credentials;

2. Provider has become a defendant in any malpractice action, receives any pleadings, notice or demands of claim, or service of process relating to alleged malpractice, or is required to pay damages in any action by way of judgment or settlement;

3. Provider becomes the subject of any disciplinary proceeding or action before participant's state licensing agency or a similar agency in any state and/or any governmental agency;

4. Provider is convicted of a felony relating directly or indirectly to the practice of chiropractic;

5. There is a change in the provider's business address;

6. Provider becomes incapacitated, as that term is defined under the state's practice act;

7. An act of nature or any event beyond provider's reasonable control that will likely interrupt all or a portion of the provider's practice for a period of 60 consecutive calendar days or that may have a material adverse effect on provider's ability to perform provider's obligations hereunder for such a period;

8. Any change in the nature or extent of services rendered by provider;

9. Any other act, event, occurrence or the like that may materially affect the provider’s ability to carry out provider’s duties and obligations under the HNS Participation Agreement;

10. The addition of another practice location or the closure of a practice location; or

11. The addition of a provider to the practice or if a provider leaves an existing practice.

# VI. Protecting Credentialing Information

HNS shall assure that confidential credentialing information is accessed, used, stored, released, and disposed of in a manner that safeguards the information and protects the integrity of the data.

HNS shall assure that non-public information (*protected credentialing information*) and the function of monitoring is restricted to those individuals who require access in order to fulfill their duties and responsibilities. While all credentialing information must be responsibly accessed and utilized, of utmost importance is confidential credentialing information that is not publicly available *(protected credentialing information),* obtained from monitoring activities. HNS has developed and implemented policies and procedures to promote the privacy and security of credentialing information, including the maintenance, dissemination, and disposal of credentialing information.

# VII. Initial Credentialing

**Purpose:**
To establish the policies and procedures for initial credentialing

**Policy:**
Initial credentialing is required for participation in the HNS Network. The following describes general policies and procedures for initial credentialing.

**Requirements to Receive an Application**
Applicants must provide HNS with the following information before they are eligible to apply for participation in the HNS Network:

- Medicare (PTAN) number; and
- Medicaid number (SC applicants); and
- License number, and
- The name or names of providers with whom the applicant will be practicing
- Address and phone number.
- If you are a **NC Provider**, acceptable evidence the provider has submitted a complete, signed participation agreement with HealthConnex (effective 03/01/20) and provided HIEA is accepting date, is submitting data to HealthConnex, as required.

**Timely Credentialing**
HNS shall use best efforts to assess and verify the qualifications of applicants and render decisions on all files reviewed during the Credentialing Committee meeting within 60 days of the receipt of a complete credentialing application.

**Determination of Complete Applications**
HNS's credentialing staff members shall make decisions about the completeness, incompleteness, and acceptability of an application.

**Complete Application**
Applicants are responsible for completion of the credentialing application, providing all requested information, and disclosing all facts that HNS would reasonably need to consider while making a credentialing decision. Providers must submit a completed credentialing application, all requested documents and the HNS Practitioner's Participation Agreement, and must attest to the accuracy and completeness of the information submitted. In this context, "complete" means:

1. All requested information has been provided
2. All signatures are received during the 180 days prior to the date of the scheduled Credentialing Committee meeting in which the file will be presented
3. All blanks on the application form are filled in and additional explanations are provided as needed


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**Incomplete Application**
Applications received by HNS that do not include all requested information to appropriately assess the provider's credentials and qualifications will be deemed "incomplete" applications.

Within 15 days from the date HNS receives an application, depending on the amount of missing information and the significance of the missing information, at the discretion of the Director of Credentialing or Credentialing Specialist, credentialing staff members may:

1. Return the application to the provider with a notice that the credentialing file has been closed. The notice will clarify what information is needed in order to complete the credentialing process. It will also encourage the provider to resubmit a complete application, but that no further action is required unless and until HNS receives another application.

2. Contact the provider, via telephone, facsimile, or letter to inform the provider that the application is incomplete and/or that requested documents have not been submitted. Credentialing staff members clarify what information is needed in order to complete the credentialing process and provide a date by which the information must be provided. If the provider fails to submit the information necessary to complete the credentialing process or is unable to submit the requested information by the due date, the provider may withdraw from the credentialing process or HNS may close the file.

3. Pend the application for an additional 60 days to allow time to obtain additional information needed to complete the credentialing process. Pended files are not submitted to the Credentialing Committee for review or approval until they are complete. If the credentialing staff members make the decision to pend an application, they notify the applicant, in writing, of the pending status.

**Withdrawal from the Credentialing Process**
Upon request, providers who do not meet HNS credentialing criteria or who have not provided the information necessary to complete the initial credentialing process may withdraw from the credentialing process. This withdrawal may occur without action by the Credentialing Committee and requires no report to NPDB or state licensing boards.

**Denial for Participation in the Network**
Providers who do not meet HNS credentialing criteria or who have not or are unable to provide the information necessary to complete the initial credentialing process after repeated requests may be denied participation.

**Timely Notification of Decisions**

HNS shall notify providers of credentialing decisions within 60 days of the date the decision was made.

**Notification of Inconsistent Information**

Any information discovered during the credentialing process that varies substantially from the information provided in the application will be communicated to the applicant, within 15 days, for further explanation. Communication may be via telephone, facsimile, or letter. The applicant shall be required to provide necessary explanation or adequately explain any failure to do so. Failure to provide required information or to adequately explain any failure to do so will result in denial of his/her request for participation.

**Notification of Changes**

Applicants must inform HNS of any material change to the information on their application. Failure to inform HNS immediately of a status change is a violation of the HNS Credentialing Plan and the Practitioner's Participation Agreement and may result in immediate denial of the application.

**False Information**

Apparent deliberate submission of false information on the application will result in denial of the application.

**Provisional Credentialing (available only to NC Providers)**

If HNS has not approved or denied the provider's initial credentialing application within 60 days of receipt of the completed application, *upon receipt of a written request from the applicant* and within five business days of its receipt, HNS may issue a provisional credential to the provider. However, HNS shall only issue a provisional credential if the applicant has a valid professional license, is eligible for participation in federal health care programs, and has no reported history of malpractice claims, substance abuse or mental health issues, or disciplinary action(s) by licensing board(s).

Following the issuance of a provisional credential, HNS shall complete the initial credentialing process and present the complete file to the Credentialing Committee for approval or denial within 60 days of the date the provisional credential was issued.

The provisional credential shall be effective upon issuance and remains effective until the provider's credentialing application is approved or denied by HNS.

A provider may only be provisionally credentialed once.

*(Reference N.C.G.S. § 58-3-230 Uniform provider credentialing)*

# VIII. Initial Credentialing Policies and Procedures

HNS shall accept the Uniform Credentialing Application for initial credentialing or as otherwise required or allowed by state law. In addition to the applicant's personal information, practice's demographic data, education and work history information, the Uniform Credentialing Application requires the applicant to address the following disclosure questions:

- Reasons for inability to perform the essential functions of the position, with or without accommodation
- Lack of present illegal drug use
- History of loss of license and felony conviction(s)
- History of loss or limitation of privileges or disciplinary actions

1. The applicant is required to provide a copy of the insurance face sheet from the malpractice insurance carrier as evidence of current malpractice insurance coverage and appropriate coverage amounts. Upon receipt, credentialing staff members verify the coverage amounts and dates of coverage.

2. Applications received by HNS that do not include all requested information to appropriately assess the provider's credentials and qualifications or do not conform to timelines will be deemed incomplete applications. Within 15 days from the date HNS receives an application, depending on the amount of missing information and the significance of the missing information, at the discretion of the Director of Credentialing or Credentialing Specialist, credentialing staff members may:

   a. Return the application to the provider with a notice that his/her credentialing file has been closed. The notice will clarify what information is needed in order to complete the credentialing process. The notice also encourages the provider to resubmit a complete application, but that no further action is required unless and until HNS receives another application.

   b. Contact the provider, via telephone, facsimile, or letter and informs the provider that the application is incomplete or requested documents have not been submitted. Credentialing staff members clarify what information is needed in order to complete the credentialing process and provide a date by which the information must be provided. If the provider fails to submit the information necessary to complete the credentialing process or is unable to submit the requested information by the due date, the provider may withdraw from the credentialing process or HNS may close the file.


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c. Pend the application for up to an additional 60 days to allow time to obtain additional information needed to complete the credentialing process. Pending files are not submitted to the Credentialing Committee for review or approval until they are completed. Credentialing staff members will notify the applicant, in writing, of the pending status.

3. Any information discovered during the verification process that is inconsistent with or varies substantially from the information provided in the application will be communicated to the applicant, within 15 days, for further explanation.

   The applicant shall be required to provide necessary explanation of any information obtained during the verification process that varies substantially from the information provided in the application or adequately explain any failure to do so. Failure to provide required information or to adequately explain any failure to do so will result in denial of his/her request for participation.

# IX. Initial Credentialing Verification and Sources

**Purpose:**
To ensure HNS receives information necessary to assess a provider's professional qualifications, prior to making credentialing decisions, and to establish the acceptable sources for obtaining the credentials

**Policy:**
HNS will conduct timely verification of information to ensure that providers have the legal authority and relevant training and experience to provide quality care. HNS will, at a minimum, verify professional education, work history, malpractice insurance coverage, current licensure, state sanctions or restrictions on licensure or limitations on scope of practice, criminal/civil convictions, and Medicare/Medicaid sanctions including exclusions from federal health care programs. HNS shall also review malpractice claims history and any affirmative responses to disclosure questions on the Uniform Credentialing Application before making initial credentialing decisions.

HNS shall use only NCQA-accepted sources to verify credentials for initial credentialing files:

- The primary source: the entity that originally conferred or issued the credential ***or***
- Another NCQA-accepted source listed for the credential

HNS subscribes to NPDB Continuous Query Service (PDS), which provides continuous querying of the NPDB for reported incidents for network providers. HNS will use NPDB Continuous Query Service as the verification source for limitations on licensure, sanctions, malpractice claims history, criminal/civil convictions, and Medicare/Medicaid sanctions. Enrolling HNS applicants in the NPDB Continuous Query Service (PDS) ensures that network providers are monitored during initial credentialing, re-credentialing, and throughout their participation in the network.

## 1. Credentials and Verification Sources

**a. Professional Education**

HNS requires applicants to be graduates of a chiropractic college. HNS will verify graduation from medical/professional school.

**b. Work History**

HNS requires providers to provide work history since graduation from Chiropractic College up to the present and to satisfactorily clarify any gaps greater than three months/90 days.

**c. Malpractice Insurance Coverage**

HNS requires current professional malpractice insurance coverage with limits of $1 million per occurrence/$3 million aggregate.

Applicants are required to produce a copy of the face sheet/declaration page of the insurance policy that displays the provider's name, dates of coverage, and amounts of coverage.

**d. Current Licensure**

HNS requires applicants to hold a current, unrestricted license to practice in the state in which providers will provide care for members through their participation in the HNS Network.

**e. Sanctions/Limitations on Scope of Practice**

HNS will review for sanctions/limitations on scope of practice for all providers applying for participation with HNS. If a provider has been licensed in more than one state within the past five years, HNS will review for sanctions in all states in which the provider was licensed during the past five years.

**f. Medicaid/Medicare Sanctions**

The applicant must be eligible to participate in federal health care plans with no sanctions. Sanctions for default on student loans may not result in denial of an application if there is evidence the loan has been repaid.

**g. Malpractice Claims History**

HNS requires a malpractice claims history acceptable to the HNS Credentialing Committee. Applicants are required to provide details regarding malpractice claims history.

**h. Criminal/Civil Convictions**

Applicants are required to provide details on any criminal/civil convictions.

**i. Review of Affirmative Responses to Disclosure Questions**

Applicants are required to provide details on all affirmative responses to disclosure questions on the Uniform Credentialing Application. The application requires the applicant to address reasons for inability to perform the essential functions of the position with or without an accommodation, lack of present illegal drug use, history of loss of license and felony conviction(s), and history of loss or limitations of privileges or disciplinary actions.

**j. Attestation as to Completeness and Accuracy of Information**

Applicants are required to attest to the accuracy and completeness of the information submitted to HNS.

**k. Previous Network Participation**

HNS may, but is not required to, consider an application from a provider whose participation was previously denied or terminated.

**m. Letters of recommendation.**
Providers must submit two letters of recommendations from professional peers.


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# X. Re-credentialing

**Purpose:**
To establish the policies and procedures for re-credentialing

**Policy:**
Re-credentialing is required for participation in the HNS Network.

The following describes the general policies and procedures for re-credentialing.

**Timely Credentialing**
HNS shall use best efforts to assess and verify the qualifications of applicants and render decisions on all files reviewed during the Credentialing Committee meeting within 60 days of receipt of a complete re-credentialing application.

HNS will re-credential all participating providers within 36 months of the month in which the provider was last credentialed by HNS. More frequent re-credentialing may occur at the sole discretion of HNS.

**Determination of Complete Applications**
HNS's credentialing staff members shall make decisions about the completeness, incompleteness, and acceptability of an application.

**Complete Application**
Applicants are responsible for completion of the re-credentialing application, providing all requested information, and disclosing all facts that HNS would reasonably consider in making a credentialing decision. Providers must submit a completed re-credentialing application, all requested documents, and the HNS Practitioner's Participation Agreement, and must attest to the accuracy and completeness of the information submitted. In this context, "complete" means:

- All requested information has been provided
- All signatures are within 180 days prior to the date of the scheduled Credentialing Committee meeting in which the file will be presented
- All blanks on the application form are filled in and additional explanations provided as needed

**Incomplete Application**
Applications received by HNS that do not include all requested information to appropriately assess the provider's credentials and qualifications will be deemed "incomplete" applications.

Within 15 days from the date HNS receives an application, depending on the amount of missing information and/or the significance of the missing information, at the discretion


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of the Director of Credentialing or Credentialing Specialist, credentialing staff members may:

- Contact the provider, via telephone, facsimile, or letter, and inform the provider that the application is incomplete and/or requested documents have not been submitted. Credentialing staff members clarify what information is needed in order to complete the re-credentialing process and provide a date by which the information must be provided. If the provider fails to submit the information necessary to complete the re-credentialing process or is unable to submit the requested information by the due date, the provider may be terminated from the network for failure to re-credential.

- HNS may choose to pend the application for an additional 60 days to allow time to obtain additional information needed to complete the re-credentialing process. Pended files are not submitted to the Credentialing Committee for review or approval until they are complete. If the credentialing staff members make the decision to pend the application, the applicant is notified, in writing, of the pending status.

**Timely Notification of Decisions**
HNS shall notify providers of re-credentialing decisions within 60 days of the date the decision was made.

**Notification of Inconsistent Information**
Any information discovered during the re-credentialing process that varies substantially from the information provided in the application will be communicated to the applicant, within 15 days, for further explanation. Communication may be via telephone, facsimile, or letter. The applicant shall be required to provide necessary explanation or adequately explain any failure to do so. Failure to provide required information or to adequately explain any failure to do so will result in termination of his/her request for participation.

**Notification of Changes**
Applicants must inform HNS of any material change to the information on their application. Failure to inform HNS immediately of a status change is a violation of the HNS Credentialing Plan and the Practitioner's Participation Agreement and may result in immediate termination from the network.

**False Information**
Apparent deliberate submission of false information on the application will result in termination from the network.

**Automatic Re-credentialing**
HNS subscribes to NPDB Continuous Query Service (PDS) which provides continuous querying of the NPDB for reported incidents for network providers. HNS will receive e-mail notifications ("alerts") from NPDB Continuous Query Service within 24 hours of a report received by NPDB. If, at any time, HNS becomes aware of an incident that has


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been reported to the NPDB, HNS evaluates the provider’s credentials by requiring him/her to complete the re-credentialing process.

HNS has established policies and procedures to monitor for quality of care complaints. If, at any time, HNS becomes aware of a quality complaint issue, other than those that would result in immediate termination, HNS evaluates the provider’s credentials by requiring him/her to complete the re-credentialing process.


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# XI. Re-credentialing Policies and Procedures

HNS shall utilize a modified version of the Uniform Credentialing Application for re-credentialing, as otherwise required or allowed by state law. These applications are system-generated by HNS and include certain pre-filled fields of providers' demographics. The provider is instructed to review the application for accuracy and correct/update any inaccurate information. The re-credentialing application requires the provider to address the following disclosure questions:

- Reasons for inability to perform the essential functions of the position, with or without accommodation
- Lack of present illegal drug use
- History of loss of license and felony conviction(s)
- History of loss or limitation of privileges or disciplinary actions

**Initial Request**
After determining which providers shall receive re-credentialing applications, credentialing staff members use best efforts to send the applications to those providers via U.S. mail 90 days prior to the expiration of the 36 month period.

The re-credentialing application is accompanied by a letter from HNS that includes the date the completed application must be received by HNS. The letter also includes the rights of the provider.

**Second Request**
If the application is not received by HNS by the stated due date, credentialing staff members attempt to contact the provider to clarify that re-credentialing must be completed per HNS's policies. Efforts to contact the provider may be made via telephone, letter, or facsimile. The provider will be notified of a new due date for submission of the completed application, which will include advising the provider that termination from the network will occur if the completed application is not received by the stated due date. The provider will also be informed of the date of termination of participation that will occur should the provider fail to submit the completed application.

If the second request does not result in a completed application by the due date, the provider's participation in the network will be terminated for failure to re-credential. Providers will receive notification, in writing, of the termination and the effective date of the termination.

1. The applicant is required to provide a copy of the insurance face sheet from the malpractice insurance carrier as evidence of current malpractice insurance coverage and appropriate coverage amounts.

2. Applications received by HNS that do not include all requested information to appropriately assess the provider's credentials and qualifications or do not conform to timelines will be deemed incomplete applications. Within 15 days from the date HNS receives an application, depending on the amount of missing information and the significance of the missing information, at the discretion of the Director of Credentialing or Credentialing Specialist, credentialing staff members may:

   - Contact the provider, via telephone, facsimile or letter, and inform the provider that the application is incomplete or requested documents have not been submitted. Credentialing staff members clarify what information is needed in order to complete the re-credentialing process and provide a date by which the information must be provided. If the provider fails to submit the information necessary to complete the re-credentialing process or is unable to submit the requested information by the due date, the provider's participation in the network may be terminated.

   - HNS may choose to pend the application for an additional 60 days to allow time to obtain additional information needed to complete the re-credentialing process. Pended files are not submitted to the Credentialing Committee for review or approval until they are completed. As soon as the credentialing staff members make the decision to pend the application, HNS notifies the applicant, in writing, of the pending status.

3. HNS shall use only NCQA-accepted sources to verify credentials for re-credentialing files. Verification includes from the entity that issued the credential, the NPDB Continuous Query Service (PDS), and the provider's completed application.

4. Any information discovered during the verification process that is inconsistent with, or varies substantially from, the information provided in the application, will be communicated to the applicant within 15 days for further explanation. Communication may be via telephone, facsimile, or letter. The applicant shall be required to provide explanation of any information obtained during the verification process that varies substantially from the information provided in the application or adequately explain any failure to do so. Failure to provide required information or to adequately explain any failure to do so will result in termination from the network.

5. If at any time, HNS becomes aware of a reported incident, through the ongoing monitoring component of the NPDB Continuous Query Service (PDS), HNS will follow the procedures outlined in the HNS Credentialing Plan.

6. HNS shall notify, in writing, each provider whose file was presented at the Credentialing Committee meeting of the decision of the Credentialing Committee.

If the provider's participation is terminated, the notification letter will include the effective date of the decision, the reason for the decision and, if applicable, the provider's right to appeal and a summary of the appeals process.



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# XII. Quality Complaints

**Purpose:**
To promote safe, effective healthcare.
HNS expects its providers to provide safe, appropriate care to their members in a clean, safe, and accessible environment

In addition to obtaining verifications of credentials as outlined here and in the HNS Credentialing Plan, HNS has established standards for HNS practice sites as well as policies and procedures for monitoring for quality of care complaints and for complaints relating to HNS Practice/Facility Site Standards. **(See HNS / Payor Policies for Accessibility and HNS /Practice Site Standards)**

**Policy:**
HNS shall record and investigate all quality complaints regarding any issue that could adversely affect the health or well-being of a member. HNS shall evaluate both the specific complaint and the provider's history of issues, if applicable.

HNS shall record and investigate all complaints regarding HNS Practice/Facility Site Standards. HNS shall evaluate both the specific complaint and the provider's history of issues, if applicable.

The provider must maintain a practice site and must comply with HNS Practice/Facility Site Standards. HNS shall record and investigate all complaints related to HNS Practice/Facility Site Standards. HNS shall set performance standards and thresholds for practice sites including, but not limited to, physical accessibility, appearance, adequacy of space, and adequacy of medical record keeping.

All information relating to quality complaints shall be presented to the Credentialing Committee at the next scheduled credentialing meeting and/or, if applicable, to the Medical Director.

The Credentialing Committee and/or Medical Director or his/her designee shall review all quality complaints and the provider's history of issues, as applicable, and make decisions regarding those complaints and the provider's history, as appropriate.

## 1. Types of Quality Complaints

**Quality Complaints**
Quality complaints are complaints regarding any issue which could adversely affect the health or well-being of a member received from a member.

**Accessibility and Practice/Facility Site Complaints**
Accessibility and Practice/Facility Site complaints are complaints related to HNS Practice/Facility Site Standards or provider accessibility received from any

source including, but not limited to, a member, client, or other provider. (Complaints or issues related to clinical documentation or clinical record keeping fall under the purview of the HNS Quality and Utilization Management Committee, not the Credentialing Committee.)

## 2. Notification to Providers

**Notification of Complaints**
If at any time, HNS becomes aware of a quality complaint issue that might endanger the health or well-being of a member, indicating the need for immediate action regarding a provider's participation status, credentialing staff members promptly notify the Medical Director of the issue. If the quality complaint does not indicate the need for immediate action, HNS will notify the provider that he/she is required to complete the re-credentialing process.

**Notification of Adverse Action**
If the Credentialing Committee or Medical Director or his/her designee determines after a review of the complaint that termination or other adverse action is necessary, the provider will receive written notification of the decision.

## 3. Monitoring of Quality Complaints

HNS reviews quality complaints as part of our ongoing monitoring, which includes complaints related to HNS Practice Site Standards.

## 4. Practice/Facility Site Standards

HNS has developed Practice/Facility Site Standards to promote the accessibility, safety and other issues.  These standards shall be posted on the HNS website (HNS/Payor Policies/Accessibility/Practice Site Requirements).

HNS monitors complaints related to HNS Practice/Facility Site Standards and conducts site visits based on the thresholds outlined below, and in the manner outlined below.

**Threshold for Site Visits**
If HNS receives more than two complaints related to any HNS Practice/Facility Site Standards regarding the same provider within any three month period or if HNS receives more than three complaints during a calendar year regarding the same provider, HNS will conduct a practice site visit. Site Visits may be conducted but are not required for complaints related to Clinical Record Keeping.

If a site visit is warranted, providers must allow representatives of HNS to conduct the site review, which will include a review of all Practice/Facility Site Standards.

*Subsequent Complaints*


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If, prior to correcting deficiencies from a site review (outlined above), a provider again meets the threshold warranting another site review, the provider's participation will be terminated.



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# XIII. Re-credentialing Verification and Sources

**Purpose:**
To ensure HNS receives information necessary to assess a provider's professional qualifications prior to making re-credentialing decisions and to establish the acceptable sources for obtaining the credentials

**Policy:**
HNS shall adhere to the following policies and procedures for providers applying for continued participation in the network.

HNS will, at a minimum, verify licensure, state sanctions, restrictions on licensure or limitations on scope of practice and Medicare/Medicaid sanctions, malpractice claims history, and criminal/civil convictions, and shall review for any quality complaints and any affirmative responses to disclosure questions on the re-credentialing application before making re-credentialing decisions.

1. HNS will review at a minimum the most recent three year period available for quality complaints.

2. HNS shall use only the following sources to verify credentials for re-credentialing files:

   - The primary source (the entity that originally conferred or issued the credential) ***or***
   - Another NCQA-accepted source listed for the credential
   - HNS internal quality complaint monitoring

   HNS subscribes to NPDB Continuous Query Service (PDS) which provides continuous querying of the NPDB for reported incidents for network providers. HNS will use NPDB Continuous Query Service (PDS) as the verification source for limitations on licensure, sanctions, malpractice claims history, criminal/civil convictions, and Medicare/Medicaid sanctions. HNS will receive e-mail notifications ("alerts") from NPDB Continuous Query Service within 24 hours of a report received by NPDB.

   HNS will also use the re-credentialing process to review new reports received from NPDB Continuous Query Service (PDS) alert notifications and for any quality complaints other than those requiring immediate actions. Credentialing staff members query the NPDB to obtain the new report and review the reported incident. Credentialing staff members also use the re-credentialing process to review new quality complaints received and, if applicable, review the provider's history of complaints/issues.


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## 1. Credentials and Verification Sources

**a. Malpractice Insurance Coverage**

HNS requires current professional malpractice insurance coverage with limits of $1 million per occurrence/$3 million aggregate.

HNS requires providers to produce a copy of the face sheet/declaration page of the insurance policy that displays the provider's name, dates of coverage, and amounts of coverage.

**b. Current Licensure**

HNS requires applicants to hold a current, unrestricted license to practice in the state in which the providers will provide care for members through their participation in the HNS Network.

**c. Sanctions/Limitations on Scope of Practice**

HNS reviews for sanctions/limitations on scope of practice for all providers applying for continued participation with HNS.

If a provider has been licensed in more than one state within the past five years, HNS reviews for sanctions in all states in which the provider was licensed during the past five years.

**d. Medicaid/Medicare Sanctions**

The applicant must be eligible to participate in federal health care plans with no sanctions. Sanctions for default on student loans may not result in denial of an application if there is evidence the loan has been repaid.

**e. Malpractice Claims History**

HNS requires a malpractice claims history acceptable to the HNS Credentialing Committee. HNS obtains confirmation of the past five years of history of malpractice settlements from the malpractice insurance carrier or from NPDB.

**f. Review of Affirmative Responses to Disclosure Questions**

Providers are required to provide details on all affirmative responses to disclosure questions on the Re-credentialing Application.

**g. Attestation as to Completeness and Accuracy of Information**

Providers are required to attest to the accuracy and completeness of the information submitted to HNS.

**h. Quality Complaints**

HNS tracks all complaints related to quality of care, accessibility and HNS practice/facility sites. Complaints may originate from members, clients,



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providers, or any other source. Verification are made within 180 days prior to the Credentialing Committee’s decision. The credentialing file shall include documentation of the verification and that the verification was within the 180 day time limit.

i. **Letters of Recommendation**
Providers must submit two letters of recommendation from professional peers.


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# XIV. Ongoing Monitoring

**Purpose:**
The purpose of ongoing monitoring is to provide a mechanism for the review of potential quality issues for network providers between credentialing cycles

**Policy:**
HNS shall conduct ongoing monitoring for all participating providers. Ongoing monitoring shall include:

- Exclusion/debarment from federal health care programs
- Medicare/Medicaid sanctions
- Sanctions/limitations on license, malpractice claims history, criminal/civil convictions
- Quality complaints
- Adverse events
- Notifications of malpractice claims received from any source.
- Complaints relating to the HNS Practice Site and Accessibility Standards.
- Compliance to 36 month timeline for recredentialing
- Identity theft (LADMF)
- CMS Preclusion List
- Information received *from any other source* that suggests the safety and well-being of a member is at risk.

HNS subscribes to NPDB Continuous Query Service (PDS), which provides continuous querying of the NPDB for reported incidents for network providers. HNS receives e-mail notifications ("alerts") from NPDB Continuous Query Service within 24 hours of a report received by NPDB.

HNS uses the NPDB Continuous Query Service (PDS) as the verification source for limitations on licensure, sanctions, malpractice claims history, criminal/civil convictions, and Medicare/Medicaid sanctions. Enrolling HNS applicants in the NPDB Continuous Query Service (PDS) ensures that network providers are monitored during initial the initial credentialing process and as long as they remain in the HNS Network and are enrolled in the PDS. If, at any time, HNS becomes aware of an incident that has been reported to the NPDB, HNS evaluates the provider's credentials by requiring him/her to complete the re-credentialing process.

HNS has established policies and procedures to monitor for quality of care complaints. If, at any time, HNS becomes aware of a quality complaint issue, other than those that would result in immediate termination, HNS evaluates the provider's credentials by requiring him/her to complete the re-credentialing process. To monitor our compliance with monitoring quality complaints, credentialing staff members generate an internal report by querying the HNS database by the 10th day of the month in order to establish

that HNS has no quality complaints or that if any quality complaints exist, they are being addressed.

## 1. Review Process

If on-going monitoring reveals an adverse occurrence, credentialing staff members initiate a review of the incident. Credentialing staff members inform the provider any time HNS becomes aware of an incident as a result of HNS's on-going monitoring process. HNS evaluates the provider's credentials by requiring the provider to complete the re-credentialing process. The initial notification may be verbal or written.

The provider is required to complete a new re-credentialing application that must include a written explanation/response of the incident. The provider is given a due date by which to comply with the request. All information received from the provider is maintained in the provider's credentialing file and/or electronically maintained in the HNS computer system. If a provider fails to submit the requested information or fails to produce other reasonably requested information needed to evaluate the adverse occurrence, the provider may be terminated from the network.

Credentialing staff members complete a Provider Summary/Occurrence Report for all adverse results discovered during on-going monitoring. This includes relevant information submitted by the provider.

The Provider Summary/Occurrence Report is presented to the Medical Director, his/her physician designee, and/or the Credentialing Committee, as applicable, based on the date HNS discovered the adverse result and based on the seriousness of the adverse occurrence.

The Medical Director, his/her designee, or the Credentialing Committee takes action, as appropriate (i.e., approve continued participation or terminate participation).

The following are other actions to improve performance that may be taken as a result of adverse occurrences identified during on-going monitoring:

a. Require the provider to review the professional and ethical standards of the applicable state licensing board and/or HNS and client policies.
b. Require the provider to submit a signed attestation statement indicating review of above.
c. Require the provider to obtain additional education approved by applicable state licensing boards.
d. Require the provider to review HNS's Compliance Training Module, which addresses compliance, fraud, waste and abuse, and HIPAA/HITECH regulations, and to submit a signed attestation statement indicating such review.

e. Require the submission of a written corrective action plan.

## 2. Notification to Provider of Termination

HNS will notify providers, in writing, of terminations that were based on results of on-going monitoring.

Notifications shall include:

- The determination
- The date of the determination
- The reason for the decision
- The effective date of the termination, if applicable
- A statement informing the provider that HNS will report the action to the appropriate authorities and the specific authorities to which reports are to be given, if applicable
- The right to appeal and information on the appeals/hearing process, if applicable

# XV. Credentialing Committee

**Purpose:**
To establish a peer-review process to ensure that HNS obtains meaningful advice and expertise from peers when making credentialing decisions

**Policy:**
HNS shall establish and maintain a Credentialing Committee to make decisions regarding credentialing files presented to the Credentialing Committee and to assure that all decisions are made in an objective, unbiased, and non-discriminatory manner.

This Committee is intended to be a medical peer review committee as that term is defined by the provisions of NCGS 90-21.22A and SCGS 40-71 and shall operate consistent with the requirements of those statutes to ensure that its protections apply to the Committee's proceedings, records and materials.


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# XVI. Credentialing Decisions

**Purpose:**
To establish the criteria and authority for decision-making, the timelines for decision-making, the documentation of the decisions, and the process for notifications of the decisions

1. **General Policies**
   HNS has the sole right to determine which physicians it will accept and maintain within its Network, and the terms on which it will allow participation.

   The Medical Director, his/her physician designee, and the Credentialing Committee shall objectively assess and verify the qualifications of all applicants and participating providers with complete credentialing/re-credentialing files. They shall render decisions in an unbiased and non-discriminatory manner.

2. **Conflict of Interest**
   Credentialing Committee members may not participate in the decision-making process for any provider with whom they have a conflict of interest.

   Exception: Credentialing Committee members may participate in the review process of other Credentialing Committee members' files or in situations when it is necessary to obtain a majority determination.

3. **Non-Discrimination**
   HNS does not make credentialing decisions based on race, ethnic/national identity, gender, age, sexual orientation, or type of patient (e.g., Medicaid).

   HNS does not make credentialing decisions based on marital status, religious creed, ancestry, status as a disabled veteran, and/or physical or mental disability. All credentialing decisions and actions are made without regard to the types of procedures provided, the types of patients in which the provider specializes, or that the provider practices in a high-risk area.

   HNS does not discriminate against any provider who acts within the scope of his or her license, under applicable state law, solely on the basis of that license.

4. **Right to Request Additional Information**
   The Medical Director, his/her physician designee, or the Credentialing Committee has the right to request further information from any provider in order to assist with the evaluation process.

   If additional information is requested, the application may be pended and credentialing staff members notify the provider, in writing, of the request for additional information. The notice includes the date by which the information


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must be received. Summarized information from the Provider Summary/Occurrence Report is presented to the Credentialing Committee at the next scheduled meeting. Failure to provide the information requested by the stated due date may result in denial or termination of the provider's participation.

## 5. Timeliness of Decision-Making

**180 Day Timeline**

HNS shall ensure that at the time of the credentialing decision all verifications and required signatures are within 180 days prior to the date the Credentialing Committee makes a determination.

**60 Day Time Line**

The Credentialing Committee shall use best efforts to assess and verify the qualifications of applicants and render decisions on all files reviewed during the Credentialing Committee meeting within 60 days of receipt of a completed application.

**36 Month Time Line**

For re-credentialing applications, the Credentialing Committee shall assess and verify the qualifications of applicants and render decisions within 36 months of the most recent credentialing date. (Exceptions may be made for providers on active duty in the military.)

## 6. Review of Credentials Outside the Credentialing Cycle

A provider may be brought to the Credentialing Committee for discussion outside the re-credentialing cycle if the HNS credentialing staff members determine that there is a question as to whether the provider continues to meet HNS criteria for participation.

## 7. Status of Applicant after Credentialing Committee Decision Date

Acceptance of an applicant into the HNS Network is conditioned upon the applicant's agreement to accept HNS's terms and conditions of participation as attested to by the applicant's signature on the Practitioner's Participation Agreement. Indication that the applicant meets the credentialing criteria does not create a contract between the applicant and HNS.

While the applicant is considered a participating provider and is eligible to treat members as of the Credentialing Committee's decision date, the provider cannot submit claims for services provided to client's members until all demographic information has been entered into HNS and client information systems and the Provider Orientation has been completed. HNS notifies providers, either via telephone, facsimile, or e-mail of the date on which he/she can begin submitting claims to HNS.

## 8. Status of Applicant after the Client’s Credentialing Committee Meeting

Acceptance of an applicant into the HNS Network is conditioned upon the applicant’s approval by the client’s Credentialing Committee. At all times the client reserves the right to approve, deny, or terminate participation for any provider. If the client notifies HNS that a provider has been denied participation, HNS must terminate the provider from the network and immediately inform the provider that he/she no longer meets HNS’s credentialing requirements.



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# XVII. Range of Actions/Authority

**Purpose:**
To establish the range of actions, other actions to improve performance, and identify who has the authority to take the appropriate action as a result of the application of decision-making criteria:

HNS has developed criteria for categorizing decision-making actions for the purpose of establishing authority, responsibilities, and procedures for processing credentialing/re-credentialing files

HNS shall establish a range of actions that may be considered during the decision-making process.

**Credentialing – Range of Actions and Authority**
Decision-making actions taken during the *initial credentialing process* shall include:

- Approval
- Provisional Credentialing (for NC providers only)
- Pending the Application
- Denial
- Rejection
- Reconsideration
- Approval of Requests to Withdraw Applications

1. **Approval**
   Approval for Level 1 and Level 2 files requires a decision by the Credentialing Committee.

   (Designation as a level 3 file can only be given to recredentialing files and level 4 files are not subject to approval.)

2. **Provisional Credentialing**
   **(NC providers only)**
   The NC Department of Insurance requires health care and managed care plans to provisionally credential providers.

   This action requires a decision by the Credentialing Committee and is available **for initial credentialing only.**

   If HNS has not approved or denied the provider's initial credentialing application within 60 days of receipt of the completed application, *upon receipt of a written request from the applicant* and within five (5)


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business days of its receipt, HNS may issue a provisional credential to the provider.

Following the issuance of a provisional credential, Credentialing staff shall complete the initial credentialing process and present the complete file to the Credentialing Committee for approval or denial within 60 days of the date the provisional credential was issued. (This file will be presented as a level 2 file.)

**SC Providers**
Provisional credentialing is not available to SC providers as it is prohibited by certain client contracts.

**3. Pending the Application**
The Credentialing Committee, the Medical Director, or his designee, and the Director of Credentialing, or her designee have the authority to pend an initial credentialing application if additional information is needed to complete the credentialing process and/or to reach a final determination.

**4. Denial (initial credentialing only)**
Level 1 files are files which meet established cred criteria, so denial is not an appropriate course of action for level 1 files.

Denial of level 2 files requires a decision by the Credentialing Committee.

(Initial credentialing applications cannot be classified as level 3 files and the Director of Credentialing and/or cred staff are not authorized to deny level 4 files.)

**5. Rejection (initial credentialing only)**
In specific situations, Credentialing staff shall have the authority to reject a credentialing application when certain criteria are met.

**6. Reconsideration (available for initial credentialing only)**
The Director of Credentialing, her designee, *together with the CEO* have the authority to jointly determine if reconsideration shall occur.

HNS may, but is not required to, consider an application from a provider whose participation was previously denied or terminated.

Should HNS accept an application which results in second denial or termination of participation, HNS will no longer accept subsequent applications from the provider. The decision of the Credentialing Committee shall be final, and the provider shall have no rights to appeal the Credentialing Committee’s decision.


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a. *Denials/terminations based on reportable actions*
   For denials/terminations based on reportable actions, HNS shall not accept applications from the provider until either 1) it has been five (5) years from the date of the denial/termination decision or 2) there has been a substantive change in the circumstances surrounding the denial/termination. If the latter, information relating to the change must be submitted prior to the initiation of the credentialing process for the re-application. The Credentialing Committee shall review the information submitted to determine if the provider will be allowed to reapply for participation. There is no guarantee that any application will be accepted or approved.

   If approved for admission to the network, the provider may be monitored as deemed appropriate by the Credentialing Committee.

   If conditions were imposed on the provider by a state licensing board which was associated with the denial/termination, evidence the conditions were satisfactorily completed shall be required prior to accepting an application for reconsideration.

b. *Denials/terminations based on non-reportable actions*
   At a minimum, applicants must not have had participation denied or terminated (for reasons other than network need or failure to timely re-credential) by HNS within the preceding six (6) months.

   In determining the length of time before a provider may reapply for participation, the Medical Director and/or the Credentialing Committee shall consider the basis for the previous denial or termination. There is no guarantee that any application will be accepted or approved.

   If conditions were imposed on the provider by a state licensing board which was associated with the denial/termination, evidence the conditions were satisfactorily completed shall be required prior to accepting an application for reconsideration.
   If approved for admission to the network, the provider may be monitored as deemed appropriate by the Credentialing Committee.

7. **Approval of Request to Withdraw Application**
   Upon request, providers shall be allowed to withdraw their application from the credentialing process provided the request to withdraw is received prior to the presentation of their credentialing file to the Credentialing Committee.

   The Director of Credentialing and/or Cred staff has the authority to approve a request to withdraw an application for credentialing.


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Requests to withdraw initial credentialing applications will be classified as level 4 files. (For more information, see **Section VIII** – **Level 4 Files**).

**Recredentialing – Range of Actions and Authority**

Decision-making actions taken during the standard *re-credentialing process* or at any time during the 36-month cycle shall include:

- Approval
- Pending the Application
- Termination
- Re-instatement (NC Providers only)
- Actions to Improve Performance

1. **Approval**

   Level 4 files are not subject to approval.

   Approval for Level 1 and Level 2 files requires a decision by the Credentialing Committee.

   Approval for Level 3 files requires a decision by the Medical Director.

2. **Pending the Application**

   The Credentialing Committee, the Medical Director, or his designee, and the Director of Credentialing, or her designee have the authority to pend a recredentialing application if additional information is needed to complete the credentialing process and/or to reach a final determination.

3. **Termination (Recred only)**

   Level 1 files are files which meet established criteria.

   Termination of level 2 files requires a decision by the Credentialing Committee.

   Termination of level 3 files requires a decision by the Medical Director.

   Only in specific situations, the Director of Credentialing and/or Credentialing staff may make a decision to terminate a level 4 files.

   - Failure to submit the recredentialing application by the stated due date after the second request has been sent (e.g., 'failure to recred'); and/or

   - Failure to provide missing/incomplete information by the stated due date after the second request has been sent; and/or



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- Request by provider for a mutually agreed upon termination (per terms of provider contract) and only if HNS' CEO has agreed to the termination.

4. **Re-instatement (Recred Only)**
   **(NC providers only)**
   Decisions to re-instate may be made by the Credentialing Committee or Medical Director, as appropriate, and is available **for re-credentialing only.**

   HNS may allow re-instatement of participation for a provider whose break in participation is 30 days or less, IF the provider's participation was terminated for administrative reasons beyond HNS' control (such as failure to provide complete credentialing information) and not for quality reasons.

   If the break in service exceeds 30 days, the provider must complete the initial credentialing process again.

   Prior to re-instatement, Credentialing staff shall, at a minimum, re-verify credentialing factors that are no longer within the credentialing timelines and those that will not be effective at the time of the Credentialing Committee's review.

   **As a general rule, HNS shall reevaluate the provider's credentials by requiring him/her to complete the re-credentialing process**. A re-credentialing packet shall be sent to the provider and will include a deadline that will ensure presentation at the next applicable Credentialing Committee meeting. The provider shall be informed that a complete application must be received within 30 calendar days before his/her re-credentialing deadline.)

   If the provider fails to submit the completed re-credentialing application and other requested documents by the stated due date or if the application, is missing information needed to complete the re-credentialing process, Credentialing staff shall contact the provider, via fax or email, to request the missing information.

   HNS has created templates for incomplete application faxes/emails which must be used when notifying providers of missing/incomplete information. These templates include deadlines for submission and informs the provider that they will be terminated from the network if all information is not received.

   Credentialing staff shall place a copy of the fax and fax confirmation sheet or email in the provider's re-credentialing file. If the provider is


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subsequently terminated for failure to submit all the necessary information to complete the re-credentialing process, a copy of the termination notice must also be placed in the provider's re-credentialing file.

**SC Providers**
Re-instatement is not available to SC providers as it is prohibited by certain client contracts.

5. **Actions to Improve Performance**
For level 2 files, the HNS Credentialing Committee has the authority to determine any actions to improve performance.

For level 3 files, the Medical Director has the authority to determine any actions to improve performance.

HNS shall review participation of providers whose conduct could adversely affect member's health or welfare.

HNS shall use objective evidence and patient-care considerations when deciding on a course of action for dealing with providers who do not meet HNS' quality standards. While termination of participation may occur as a result of Medicare/Medicaid sanctions, sanctions or limitations on licensure, complaints, or adverse occurrences identified during ongoing monitoring, HNS may recommend actions to improve performance of those providers with whom there is a quality concern.

HNS may take the following actions to improve performance as a result of credentialing decisions made during the standard re-credentialing process, *or at any time during the 36-month cycle as a result of ongoing monitoring activities*. Actions may include:

1. Require the provider to review the professional and ethical standards of the applicable state licensing board and/or HNS and client policies.

2. Require the provider to submit a signed attestation statement indicating review of above.

3. Require the provider to obtain additional education approved by applicable state licensing boards and to provide evidence to HNS of completion of such CE.

   Effective 04/01/15, providers with a monetary judgment associated with a malpractice claim, must complete four (4) hours of HNS-approved continuing education in Clinical Risk Management and provide HNS with a certificate from the sponsoring body, indicating


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successful completion of the CE program, within 90 days from the date the provider was notified of this requirement.

**Effective 09/01/19**, providers for which the Credentialing Committee may have expressed concerns regarding clinical competency or compliance to standards of care may be required to complete four (4) hours of HNS-approved continuing education in Clinical Risk Management and provide HNS with a certificate from the sponsoring body, indicating successful completion of the CE program, within 90 days from the date the provider was notified of this requirement.

HNS shall deem the CE program(s) acceptable if approved by NC or SC Licensing Boards, and will also accept the following specific CEUs from Chirocredit.

- Risk 115 Administrative and Clinical Risk Management (**3 hours)**
- Risk 111 Malpractice Primer **(1 hour)**
- Risk 108 Identifying & Managing a Complication from Manipulation **(1 hour)**

4. Require the provider to review HNS' Compliance Training Module, which addresses compliance, fraud, waste and abuse, and HIPAA/HITECH regulations and to submit a signed attestation statement indicating such review.

5. Require the provider to review the HNS Practice Site and Accessibility Standards and to submit a signed attestation statement indicating such review.

6. Require the submission of a written corrective action plan.

7. Require the submission of health care records.

8. Other actions as may be determined by the Medical Director or Credentialing Committee.

# XVIII. Target Criteria for Credentialing and Re-credentialing

To promote consistency in determinations, HNS has established target criteria for the approval and denial of credentialing and re-credentialing files.

Credentialing staff shall review all applications for initial and continued participation against established criteria.

The Credentialing Committee, Medical Director and Director of Credentialing (or her designee) shall consider all credentialing criteria in the decision-making process.

Criteria for participation in the HNS network shall include:

1. **Application**
   Evidence of receipt of complete credentialing or re-credentialing application including but not limited to a current and signed provider attestation/authorization statement confirming the correctness and completeness of the application, all requested documents needed to complete the credentialing/re-credentialing process, and a signed Practitioner's Participation Agreement, the exhibits to that Agreement as well as the signed EDI Agreement. *(The provider's name must appear in the signature line of the PPA and all applicable attachments.)*

   In addition to above, criteria for participation includes the following:

   a) Evidence that all signatures in the credentialing application are within 180 days prior to the date of the credentialing decision.

   b) Evidence of acceptable responses to any gaps in work history, from the time of graduation from Chiropractic College to present.

   c) Other than the exceptions below, no affirmative responses to disclosure questions on the credentialing/re-credentialing application that, in the opinion of the Credentialing Committee, have not been satisfactorily explained.


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**Exceptions**

- Exceptions may be made if an affirmative response is provided for questions regarding Medicare/Medicaid sanctions or exclusions, but at the time the application is received, the provider is eligible to participate in federal healthcare plans (initial credentialing)

- Exceptions may be made if an affirmative response is provided regarding criminal/civil convictions but the conviction was not related to controlled substances, illegal drugs, violence, insurance or health care deceit, fraud or abuse, or misrepresentation.

d) Lack of evidence of apparent deliberate falsification of an application or apparent deliberate submission of false information to HNS.

e) For initial credentialing of providers, receipt of two (2) letters of recommendation on an HNS-approved form from peers (recommendations cannot be from a relative, partner, associate, employed provider or independent contractor practicing at the same location).

f) The provider has attested to his/her compliance to HNS Practice Site Standards.

g) Evidence the provider has an active Medicare Provider Number (PTAN).

h) For SC providers, evidence the provider has an active SC Medicaid number. (Effective June 1, 2015.)

i) For providers with practices in more than one state in the HNS Service area, the provider must have separate TINs for locations in each state. (Effective 05/01/17.)

j) Evidence of results of credentialing/re-credentialing verifications found acceptable by the Credentialing Committee.

**2. Education and Training**

Evidence the provider successfully completed Chiropractic College.

Evidence the provider has complied with continuing education requirements established by HNS or licensing boards.

*(Effective for providers credentialed in, or after, October, 2017).*
Within 20 days of the effective date of participation, evidence the provider has successfully completed the following continuing education programs:


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- HNS “Improving Quality & Outcomes through Excellence in Clinical Documentation”; and
- HNS Compliance Training; and
- HNS Comparative Practice Patterns Review.

3. **License**

Evidence the provider is in good standing with his/her licensing board in the state(s) in which the provider is licensed and maintains a practice.

- Exceptions may be made for licensure sanctions provided they are not related to a safety or quality of care issue, and provided the license is still active and is otherwise in good standing with the licensing board.

- Exceptions may be made if the provider has been placed on probationary status, has met all requirements associated with the sanction imposed by the licensure board, and the license board indicates the license is in good standing.

Evidence of history of loss of license, restrictions or disciplinary actions found acceptable by the Credentialing Committee after review of frequency, severity, patterns and trends. As a general rule, “acceptable” means evidence the provider has not been subjected to three (3) or more separate orders or stipulations by a professional licensing board during the provider’s professional career. The Credentialing Committee shall evaluate the facts and circumstances surrounding any disciplinary actions to determine whether such disciplinary action constitutes evidence of probable ongoing substandard professional performance.

In cases in which there is an action pending against the provider’s license, the Credentialing Committee reserves the right to deny the application.

If the provider’s license should lapse, is suspended, revoked, or terminated, and he/she continues to practice chiropractic without a valid license during that time, the Credentialing Committee reserves the right to terminate the provider’s participation in the HNS Network, to determine whether he/she will be allowed to rejoin, and if so, when.
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4. **Malpractice**

**Evidence**:
Evidence the provider has malpractice insurance coverage in amounts acceptable to HNS (minimum $1 million/$3 million) and has maintained such coverage during his/her participation in the HNS Network.

**Immediate Termination:**

Participating providers who do not have malpractice coverage shall be terminated from the HNS Network immediately (term date will be business day following confirmation by HNS that no coverage is in place). In such situations credentialing staff shall immediately notify the CEO and shall prepare a draft Notice of Termination and send to the CEO. (Note: if the termination does not coincide with the 10th, 20th, and 30th check cut payer notification, the AP dept will be responsible for notifying the payers of the provider's termination). As with all decisions to terminate a provider's participation, Cred staff shall also determine if other providers are in practice with that physician and if so, shall notify the CEO who will prepare administrative Notices of Termination for those providers (Level 5).

**Administrative Termination:** Because the HNS Practitioner's Participation Agreement makes clear that providers must maintain malpractice insurance during his/her participation, terminations related to loss of malpractice coverage and/or failure to obtain the required tail coverage shall be treated as an administrative (Level 5) termination.

**Lapse in Coverage:**
If a provider has a lapse in coverage for any time period while he/she is participating in the HNS Network, they will be given 10 business days to provide HNS with evidence they obtained tail coverage for the period in which the coverage lapsed.

(If the provider chooses not to or is unable to obtain tail coverage his participation will be terminated immediately. He/she will not be eligible to reapply for participation until after 3 years from the date the lapse in coverage ended).

**History:**
Evidence of malpractice claims history (including open, pending, settled, arbitrated, mediated or litigated claims, and/or otherwise reported claims), which, after review of frequency, severity, patterns and trends by the Credentialing Committee, is found acceptable by the Credentialing Committee.

5. **Criminal/Civil Convictions**

   For initial credentialing, lack of a criminal history of any felony convictions or misdemeanor convictions related to controlled substances, illegal drugs, violence, alcohol, insurance or health care deceit, fraud or abuse, misrepresentation or violence within the preceding five (5) years. (Consideration may be given if the conviction was prior to initial professional licensure). Conviction shall include a plea or verdict of guilty or a conviction following a plea of nolo contendere


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For re-credentialing, lack of criminal history for convictions of any felony or misdemeanors related to controlled substances, illegal drugs, violence, alcohol, insurance or health care deceit, fraud, abuse or misrepresentation (unless the misdemeanor conviction occurred prior to initial credentialing). Conviction shall include a plea or verdict of guilty or a conviction following a plea of nolo contendere.

6. **Professional/Ethical Conduct**

   Lack of evidence of an arrest or conviction for acts of inappropriate or unprofessional conduct or acts moral turpitude, or action(s) against license for moral turpitude. (For purposes of this policy, HNS defines “moral turpitude” as conduct that is contrary to justice, honesty, or morality. Consideration may be given if the conviction was prior to initial professional licensure).

   Lack of evidence of failure to adhere to generally accepted professional and ethical standards including, but not limited to, those established by licensing boards.

   No evidence that the provider has engaged in any activity involving dishonesty, fraud, abuse, deceit or misrepresentation. Should the provider be notified of any formal action by any government or regulatory body that he/she is under investigation for any activity involving dishonesty, fraud, abuse, deceit or misrepresentation, there is evidence the provider notified HNS of the formal action within 30 days from the date he/she became aware of the action. (Added 12/04/18)

   Credentialing Committee reserves the right to terminate or deny the application if the Committee has reasonable grounds to believe that a provider is or has been engaged in felonious or fraudulent activity or engaged in conduct that may negatively reflect on the integrity and reputation of HNS, its contracted providers and/or clients.

   Except in the event of serious accident, illness, injury, or death, no evidence the provider voluntarily left his/her practice without making appropriate arrangements for the continuation of chiropractic care for those patients under active care.

   For re-credentialing, the provider has maintained a productive working relationship with HNS and HNS’ clients.

7. **Federal Health Plans**

   Evidence the provider is eligible for participation in federal health care plans and/or has no sanctions. Sanctions for default on student loans may be allowed provided the loan has been or is being repaid. Penalties related to CMS Physician Quality Reporting System (PQRS) will not, at this time, result in denial or termination of participation.

8. **CMS Preclusion List (effective April, 2019)**
   Evidence the provider's name does not appear on the CMS Preclusion List and therefore is eligible to receive payment for Medicare Advantage items or services or Part D drugs furnished or prescribed to Medicare Beneficiaries. (i.e., if a provider's name is on the list, he/she is not eligible for participation with HNS.)

9. **LADMF**

   Evidence the provider's name does not appear on the Social Security Administration's Limited Access Death Master file (LADMF). (i.e., if a provider's name is on the list, he/she is not eligible for participation with HNS.)

10. **Quality Concerns**

    Absence of safety and/or quality concerns that, in the opinion of the Medical Director and/or Credentialing Committee, could adversely affect the health and well-being of members.

11. **Compliance**

    For continued participation, evidence of compliance to laws, regulations, and HNS Policies, programs and protocols intended to ensure the consistent delivery of quality, cost-effective health care.

12. **Fraud, Waste and Abuse (FWA)**
    No evidence of conviction for crimes related to fraud, waste and abuse.

    For *active* HNS Providers, or *providers applying for participation*, no evidence the provider is under investigation, by any organization or authoritative body, for fraud, waste or abuse. **(Added 02/01/20)**

13. **Relationship with HNS/Client**

    No evidence the provider has failed to consistently maintain a cooperative, productive working relationship with HNS or a client and/or failed to timely provide information requested by HNS or by a client, which the provider is required to provide.

14. **HNS Practice Site Standards**

    For providers joining the network, evidence the provider has met HNS Practice Site Standards, including but not limited to, access/availability standards and accommodations for individuals with disabilities.

    For providers recredentialed after 01/01/17, evidence the provider complies with HNS Practice Site Standards including but not limited to, access/availability standards accommodations for individuals with disabilities.

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*Exceptions*


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Providers in the network prior to June 1, 2015, whose practice sites do not meet ADA requirements shall be allowed to remain in the network, provided all other credentialing criteria are met.

Additionally, providers seeking to join the network who will be practicing with a provider whose practice site does not meet ADA requirements will be allowed to join the network, provided all other credentialing criteria is met.

Exceptions to this requirement may also be made if the practice is in an underserved area.

Exceptions may also be made if the practice is housed in a building designated as a historical landmark and appropriate evidence of the designation is provided to HNS. (Added 04/01/19)

For re-credentialing, if HNS is required to conduct a site visit as a result of a complaint regarding HNS Practice Site Standards, evidence of a passing score from the site review, and/or if submission of a satisfactory corrective action plan (CAP) was required, evidence of an acceptable CAP and evidence, if applicable, of a passing score on the follow-up site visit, pursuant to HNS timelines.

**15. Business Need**

There is a business or organizational need for the provider's participation in the network. HNS may, from time to time, decide to discontinue accepting provider applications for membership, or decide not to renew existing Practitioner Participation Agreements, or to terminate a provider's participation.

In making such decisions. HNS may review the following:

a. Number of covered lives in a geographic area to justify expanding the physician network, and/or

b. Number of physicians in a geographic area resulting in the absence of adequate levels of steerage to existing provider network, and/or

c. claims volume, and/or

d. Number of participating physicians in a geographic area available to provide care to patients whose healthcare plans contract with HNS.

**16. Previous Participation**

The applicant has not been denied initial participation or had participation terminated (for reasons other than network need), for a non-reportable action, by HNS within the preceding six (6) months. For initial credentialing, the applicant has not been denied initial participation or had participation terminated if the

denial/termination was based on a reportable action which occurred within the previous five (5) years.

17. **Support of HNS Clinical Integration Initiatives**
    To be allowed to join or rejoin the HNS Network, lack of evidence which indicates the provider was not or is not committed and/or willing to consistently work collaboratively towards HNS' clinical integration objectives.

18. **Other Requirements**
    Evidence the provider practices chiropractic within the HNS service area.

    The provider is practicing only in a permanent, fixed, professional office, located within the HNS service area. HNS defines professional office sites as a medical office building, a commercial business building, a free-standing office or clinic, a facility whose primary business purpose is the delivery of healthcare services, or a house converted entirely to a professional office for the provision of healthcare services. Traditional commercial office sites do *not include* mobile chiropractic offices, practices located within health clubs, gymnasiums or other athletic facilities, salons/spas, or within facilities whose primary business purpose is other than the delivery of healthcare services. Criteria may be waived if the provider is practicing in an underserved area and has obtained approval from HNS, or if there are other circumstances found acceptable by the Credentialing Committee.
    ***Primary Practice Location (Full-time Practice Required)***
    The provider is in full-time practice at a *primary location* with normal business hours of at least 24, and the 24 hours are during the traditional work week (Monday-Friday).

    **Exceptions:**
    This criterion may be waived 1) if the primary practice location is an area that HNS has determined is an underserved area, and 2) HNS has given approval for the reduction in business hours or 3) if there are other circumstances found acceptable by the Credentialing Committee.
    (If HNS has waived this requirement, the applicable Credentialing Committee meeting minutes must reflect this.)

    **Other Practice Locations**
    HNS providers in full time practice at their *primary location* may also choose to practice additional hours at any other practice in the HNS service area, provided:

    a) He/she continues to work 24 hours during the traditional work week (Monday-Friday) at his/her primary location; and

    b) The additional location is open to provide chiropractic care at least 24 hours during the traditional business week (Monday-Friday), and


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c) That chiropractic care provided at the location is provided solely by an HNS Provider (or by a combination of HNS Providers) such that the location can provide chiropractic care by HNS providers for a total of 24-hour business hours during the traditional work week, and

d) The provider has notified HNS of the additional practice location, via the submission to HNS of an Additional Location Form.

***Additional Practice Locations***
As a general rule, any secondary or additional practice location must be open to provide chiropractic care at least 24 hours during the traditional business week (Monday-Friday).

**Exceptions:**
This criterion may be waived 1) if the additional location is in an area that HNS has determined is an underserved area, and 2) HNS has given approval for the reduction in business hours or 3) if there are other circumstances found acceptable by the Credentialing Committee. (If HNS has waived this requirement, the applicable Credentialing Committee meeting minutes must reflect this.)

HNS providers in full time practice at their *primary location* may also choose to practice additional hours at any other practice in the HNS service area, provided:

a) He/she continues to work 24 hours during the traditional work week (Monday-Friday) at his/her primary location; and

b) The additional location is open to provide chiropractic care at least 24 hours during the traditional business week (Monday-Friday), and

c) That chiropractic care provided at the location is provided solely by an HNS Provider (or by a combination of HNS Providers) such that the location can provide chiropractic care by HNS providers for a total of 24 hour business hours during the traditional work week, and

d) The provider has notified HNS of the additional practice location, via the submission to HNS of an Additional Location Form.

**Other Acceptable Scenarios**
Other than as noted above, providers may be eligible for participation in the HNS Network regardless of the number of hours they work each week, provided they are working at a practice (or practices) staffed only by chiropractors credentialed by HNS, the practice is open a minimum of 24 hours per week, and they are not working as a locum tenens provider anywhere in the HNS service area.

**Example:** Dr A is selling his practice, but wants to keep working part-time, but only wants to work 1 day each week.

That is acceptable provided 1) he will be working at a practice which is open at least 24 hours per week and 2) the practice is staffed only by chiropractors participating with HNS and 3) he is not working as a locum tenens provider anywhere in the HNS service area.

*Other Employment*

HNS and contracted health care plans maintain various policies/procedures which must be followed when providing chiropractic services to members whose health care plans contract with HNS. For initial and continued participation, lack of evidence the provider is employed to provide chiropractic services at an entity which would prevent or preclude the provider from consistently complying with HNS Policies and those of health care plans contracted with HNS.

*All In-All Out Policy*

Evidence that, if the provider practices in a location with another practicing chiropractor, all chiropractors at the location are participating with HNS. (This includes independent contractors who may maintain a practice within another provider's office.)

*Participation with HIEA (HealthConnex -**NC Providers Only***

Evidence the provider participates with HealthConnex unless HNS has received written confirmation from HIEA or NC DHHS which indicates the provider is exempt from participation and/or has received an extension of time in which to participate and the credentialing application is to be presented to the HNS Credentialing Committee during this time frame.

# XIX. Notifications of Credentialing Decisions

## 1. Notifications to Providers

HNS will use best efforts to notify providers of credentialing decisions within 10 days of the date of the Credentialing Committee's decision or of the decision of the Medical Director, if applicable. In all cases, HNS will notify providers within 60 days of the date of the credentialing decision.

Notifications shall include:

For approval of initial credentialing or re-credentialing:

- The date of the decision and the effective date of participation

For denials/termination, at a minimum, the notifications shall include:

- The reason for the denial/termination
- The effective date of the denial/termination
- A statement informing them that HNS will report the action to the appropriate authorities and the specific authorities to which it will be reported, if applicable
- The right to appeal and information on the appeals/hearing process, if applicable

## 2. Notifications to Clients

Information provided to each client will be specific to each client's requests, but shall include at a minimum:

For approval of initial credentialing:

- The provider's name, date of the decision, and the effective date of participation

For termination of re-credentialing and on-going monitoring activities:

- The provider's name
- The reason for the termination
- The effective date of the termination

## 3. Timelines for Notification of Approvals

Clients will be notified of the addition of newly credentialed providers within 10 days after the date of the Credentialing Committee’s decision.

## 4. Timelines for Notification of Termination

Whenever possible, HNS notifies clients of terminations in advance of the termination. Best efforts shall be made to notify clients 10 days in advance of terminations.

# XX. Right to Appeal Adverse Decisions

**Purpose:**
To establish the credentialing decisions that may be appealed and the process by which reconsideration shall occur.

HNS has established an appeal process which defines when and how a provider may appeal credentialing decisions.

In addition to below, HNS has developed policies and procedures regarding appeals and hearings. HNS shall conduct the appeals process according to HNS Credentialing Policies and within established timeframes.

HNS shall establish criteria regarding when providers may appeal adverse credentialing decisions:

**Initial Credentialing**

HNS **may, but is not required to,** allow all providers to appeal denial decisions that were based on any quality issues and/or quality complaint that, in the opinion of the Medical Director or Credentialing Committee, indicate:

- Deficiencies/concerns regarding quality of care which could adversely affect the health or well-being of a member

**Participating Providers**

Consistent with CMS requirements, HNS shall allow participating providers to appeal adverse credentialing decisions.

1. **Appeal Rights**

   Providers who have a right to appeal shall have the following rights:

   - To be notified that a professional review action has been brought against them;
   - The action taken by HNS as a result;
   - The reason for HNS' action;
   - A summary of the appeal rights and process;
   - The right to request a hearing for reconsideration of the decision within 30 calendar days from the date of the denial/termination notice;
   - To be advised that failure to submit request for a hearing within 30 calendar days of notification will result in forfeiture of the appeal right;
   - The right to have an attorney or other support person present at the hearing; and
   - Receive written notification of the final decision, which shall include



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the reasons for the decision.

2. **Notification of Rights**
   HNS shall provide written notification to providers of their right to appeal those credentialing decisions that may be appealed and their rights regarding the appeals process.

3. **Hearings**
   Providers with appeal rights shall have the right to a hearing, pursuant to HNS Credentialing Policies.

   HNS shall establish a Hearing Panel on an ad hoc basis when HNS receives a request for an appeal for those credentialing decisions which afford providers the right to appeal.

   The members of the Hearing Panel shall consider and make a final determination based on all of the information and evidence produced during the appeals process.

   HNS shall notify the provider, in writing, of the Hearing Panel's decision including the basis for the decision.  The decisions of the Hearing Panel are final.

   The Panel is intended to be a medical peer review committee as that term is defined by the provisions of NCGS 90-21.22A and SCGS 40-71 and shall operate consistent with the requirements of those statutes to ensure that its protections apply to the Panel's proceedings, records and materials.

   In lieu of a hearing, providers shall have the right to request a written review of the initial credentialing decision. HNS has established an appeal/ written review process which is governed by specific requirements and timelines.

   Contemporaneous minutes shall be taken for all hearings and shall reflect, at a minimum, all decisions made by the Hearing Panel.

   Credentialing meeting minutes shall reflect the names of any provider who appeals a credentialing decision and the outcome of the appeals process.

   All documents relating to the appeals process shall be stored electronically in a secure environment.

# XXI. Hearing

If the provider has the right to appeal, providers shall have 30 days from the date of the termination notice to request an appeal hearing for reconsideration of the credentialing decision. If a request for a hearing is not received at HNS within 30 days of the date of the notice of termination, the provider forfeits his/her right to appeal the decision and/or to an appeal hearing.

Requests must be sent to HNS, in writing, to HNS. Requests must include the specific reasons why the provider believes that reconsideration should occur.

Prior to scheduling a hearing, HNS may require the provider to submit additional information in support of his/her request for reconsideration. If additional information is requested by HNS, the provider must submit the information by the stated due date. The provider forfeits all rights to the appeal process if the provider fails to submit information requested by the due date.

HNS schedules hearings within 60 days of receipt of the request for a hearing, or if additional information is requested, within 60 days of HNS's review of the requested information.

The time and date of a hearing are communicated to the provider in writing.

The provider forfeits all rights to the appeal process if the provider fails to appear at the hearing at the time and date specified.

All hearings shall be held at the HNS offices in Cornelius, NC.

HNS shall establish a hearing panel for reconsideration of credentialing decisions which afford providers the right to appeal, and to make final decisions regarding a provider's participation.

This Panel intended to be a medical peer review committee as that term is defined by the provisions of NCGS 90-21.22A and SCGS 40-71 and shall operate consistent with the requirements of those statutes to ensure that its protections apply to the Committee's proceedings, records and materials.

The Hearing Panel shall be comprised of at least 3 physicians, appointed by HNS, who are not in direct economic competition with the provider appealing the credentialing decision, and who have not acted as accuser, or initial decision-maker in the matter. The majority of the physicians

serving on the Hearing Panel must be clinical peers in the same specialty as the provider appealing the decision.

Providers have the right to have one person attend the hearing. This individual may be an attorney or another person of the provider's choosing. The provider may not be accompanied by more than one person at the hearing. If the provider chooses to be accompanied by an attorney or other individual, no later than five days prior to the date of the hearing, the provider must provide HNS with the name of the individual.

At the hearing, the physician will be provided an opportunity to present his/her reasons for requesting reconsideration. The members of the Hearing Panel shall consider, and make a final determination based on all of the information and evidence produced during the credentialing process and during the hearing, including summary oral and written statements.

Providers are notified of the decision of the Hearing Panel, in writing, within 15 days of the date of the hearing. The written notice includes the basis for the decision.

All decisions rendered by the HNS Hearing Panel are final.


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# XXII. Notification to Authorities

**Purpose:**
To establish those actions that HNS will report to the appropriate authorities

1. **Reportable Actions**
   HNS shall report terminations/denials of participation that are based on:

   a. Quality issues relating to competency or professional conduct that, in the opinion of the Medical Director or Credentialing Committee, indicate substandard care or that could adversely affect the health, safety, or well-being of a member.

   b. A combination of sanction(s) or restriction(s) to the license related to a quality of care issue and malpractice claims history that indicates a potential safety, competency or quality of care concern.

2. **Non-Reportable Actions**
   Except as noted above, other terminations/denials are not reportable by HNS.

3. **Reportable Authorities**
   HNS reports reportable actions to the NPDB and applicable state licensing boards.

4. **Timelines for Reporting**
   Reportable occurrences shall be reported to appropriate agencies as soon as possible but in all cases, within 30 days of the Credentialing Committee's decision.

   Receipt of a written appeal for reconsideration of a credentialing decision decisions does not impact HNS' requirement to report the decision.

   If the original decision is appealed and reversed by the Hearing Panel, HNS shall notify authoritative bodies of the reversal within 30 days of the date the decision was made by the hearing panel.