October 5, 2023

PROCESS FOR PROVIDER DISPUTES REGARDING PROFESSIONAL COMPETENCE OR CONDUCT REVISED – EFFECTIVE NOVEMBER 7, 2023

In accordance with the URAC 8.1 Health Plan Standards, the process for disputes regarding professional competence or conduct has been revised effective **November 7, 2023**.

Community Health Choice will offer providers one level of appealing participation in the Community Health Choice network as follows:

A. ALL PROGRAMS

Initial Investigation:

1. The CEO, Medical Director, MCMC, QIC, or NAC:
   Initiates investigation
   Requests and reviews documentation of investigation to determine one of the following actions:
   (1) Suspend Provider
   (2) Terminate Provider
   (3) No action required

B. Results of Investigation

a. The CEO or Medical Director informs the Provider of their suspension or termination and offers the Provider the appeal hearing process.
   i. The affected physician is given written notice of the reasons for the action, including, if relevant, the standards and profiling data used to evaluate the physician as well as the numbers and mix of physicians needed by Community. Community allows the physician to appeal the action and provides a written notice of his/her right to a hearing, and the process and timing for requesting a hearing.
   ii. Provider has the following options:
      - If the Provider does not file an appeal, no further action is needed.
      - If the Provider wants to file an appeal hearing, they have to file within 30 calendar days of Community's written notice.
        - The affected Provider must indicate, within the written request, the need for an expedited review, which is scheduled based on the earliest availability of the appeal panel. An expedited appeal will be conducted within ten (10) calendar days of the receipt of the Provider's written request. When the request is received, a panel will be selected and will meet within the ten (10) day timeframe. The Provider is allowed the same process as provided in section C of this policy. Results of the expedited appeal will be communicated to the

Provider by phone and in writing within two (2) business days of the final decision.

- The written acknowledgement and notification is provided at least 60 days prior to the date of the hearing. The notice will include a statement that the Provider may either appear in person before the panel on the scheduled hearing date and/or submit a written statement to the panel at least ten (10) calendar days prior to the hearing date.

C. Provider Appeal Hearing

1. The Medical Director convenes an appeal panel.

b. Community ensures that the three hearing panel members are peers of the affected physician, with at least one being of the like specialty who is not involved in network management.
c. At the hearing, both Community and the Provider have the right to:
    i. Call, examine or cross-examine witnesses;
    ii. Be present at the hearing and represented by an attorney, who may present the evidence and argue the case at the hearing, advise his/her client and participate in resolving procedural matters. The practitioner must notify Community that he/she intends to be present in person with the name and address of the attorney, if any at least ten (10) calendar days prior to the date of the hearing
d. Circumstances prompting the consideration of investigation, corrective action or termination are discussed. The requesting Provider may appear in person, submit supporting documentation, and be accompanied by a representative.

2. Provider Appeal Panel conducts the review, makes final determination, and advises MCMC of their decision in writing within twenty (20) calendar days.
3. Credentialing staff mails a letter to the Provider with a notification of the outcome within 60 calendar days after the hearing closure.
    a) If the panel's review results in reversing the previous action, the Provider is notified, and network participation is re-instated.
    b) If the decision is to uphold the previous action, the Provider is mailed a letter inclusive of the appeal panels' findings.

If the decision is to terminate the Provider's credentials, the members receiving care from the Provider shall be notified 30 days prior to the effective date of the termination through the Member Services department. If however, the Provider is terminated due to imminent harm to the member's health or immediately terminated for reasons set forth in the Provider's contract with Community, the members receiving care from this Provider shall be notified immediately.

This policy will be reviewed by the Medical Care Management Committee at least annually and more often if necessary. Community has previously offered two levels of appeal, this notice serves as notification of the change in time frames and that there will only be one level of review.