

Medical Management Program Corrective Action Plan

PURPOSE: This procedure statement outlines how BlueCross BlueShield of Tennessee, Inc., and its affiliated companies, ("the Plan") may initiate corrective actions if a participating Provider fails to comply with applicable medical management requirements set forth in section I, below. This statement also outlines how the Plan will process denials of initial applications. The Plan's medical management programs include Provider credentialing, utilization review, quality management and Member grievance resolution activities that are overseen by professional review committees. The Plan's Board of Directors has designated the Quality Oversight Committee and its subcommittees (the "Committees") as the professional review committees responsible for performing peer review activities in accordance with the Federal Health Care Quality Improvement Act (the "HCQIA"), TCA section 63-6-219 and other applicable laws governing the organization and operation of professional peer review or medical review committees (the "Peer Review Laws").

The Plan's staff has been authorized to provide necessary support services to the Committees. Members of the Board, Committee Members, staff Members and anyone providing information to those Committees are intended to be protected against liability to the fullest extent permitted by the Peer Review Laws. The terms of this Procedure statement have been incorporated by reference into the Plan's Provider participation applications and agreements. As partial consideration for being permitted to apply to become a participating Provider and, if applicable, selected to participate in the Plan, participating Providers agree that they shall not seek to hold the Plan or such individuals liable for acts taken in good faith in accordance with this Procedure statement.

This procedure only applies to matters that involve Committee actions. Matters that do not involve Committee actions include: the non-acceptance of a participation application because the Provider fails to satisfy the Plan's pre-credentialing application standards (e.g. failure to provide evidence of licensure or insurance), the termination of a Provider's participation other than by reason of that Provider's failure to comply with applicable participation requirements (e.g. the participation agreement is terminated without cause); and disputes related to claims payment or authorization decisions. Such matters must be resolved in accordance with the Plan's Provider Dispute Resolution Procedure statement.

Records or information concerning the activities of the Committees shall be treated and maintained as privileged and confidential peer review records to the fullest extent permitted by the Peer Review Laws. Reports to the Committees, the Board of Directors or regulatory agencies concerning actions taken pursuant to this procedure statement shall not alter the status of such records or information as privileged and confidential information.

I. PARTICIPATION REQUIREMENTS

The Plan's Chief Medical Officer or his designee (the "Chief Medical Officer") will monitor participating Providers' performance to ensure that they comply with the Plan's participation requirements. The following is intended to provide a non-exclusive summary of those participation requirements:

- A. Participating Providers shall cooperate, in good faith, to facilitate the Plan's medical management activities. Such cooperation includes returning telephone calls, responding to written inquiries or requests from the Plan, providing information and documents requested by the Plan and cooperating with Plan staff Members as they perform their medical management activities.

- B. Participating Providers shall render or order Medically Necessary and Appropriate services for Member-patients.
- C. Participating Providers shall obtain prior authorization of services in accordance with applicable Plan medical management program policies and procedures.
- D. Participating Providers shall comply with accepted professional standards of care, conduct and competence.
- E. Participating Providers shall continue to satisfy the Plan's credentialing requirements as set forth in the Plan's Credential Process, including, without limitation:
 - 1. The Provider's licenses or certifications must be in good standing.
 - 2. The Provider's liability insurance coverage must remain in full force and effect.
 - 3. There have been no unreported material changes in the Provider's status such that the credentialing information submitted to the Plan is no longer accurate.

II. CORRECTIVE ACTIONS

A. INVESTIGATION

The Plan's staff will investigate and report any apparent non-compliance with the participation requirements to the Chief Medical Officer or his designee, after making a reasonable effort to obtain material facts concerning that matter. Providers must submit requested information and fully cooperate with those staff members as a condition of their continued participation in the Plan. Staff members or the Chief Medical Officer may, at their discretion:

- 1. Consult with the Provider;
- 2. Review material documents, including Members' medical records; or
- 3. Contact other Providers or persons who have knowledge concerning the matter being investigated.

B. BASIS OF ACTIONS

The Chief Medical Officer or a Committee may initiate a corrective action if a participating Provider does not comply with applicable participation requirements, and:

- 1. There is a reasonable belief that the action will promote the objectives of the Plan's medical management program.
- 2. There has been a reasonable effort to obtain the facts concerning the Provider's alleged non-compliance.
- 3. The proposed action is reasonably warranted by the facts known after the investigation has been completed.

C. ACTIONS BY THE CHIEF MEDICAL OFFICER

Upon determining that a participating Provider has not complied with the Plan's participation requirements, the Chief Medical Officer may initiate corrective actions including, without limitation:

1. Counseling the Provider concerning specific actions that should be taken to address identified problems. A summary of the counseling session and the plan of corrective action will be included in the Provider's credentialing file.
2. Submitting information regarding the Provider's conduct to the appropriate Committee for further consideration and action.
3. Imposing corrective actions, following the issuance of a "notice of corrective action" including without limitation:
 - a. Imposing practice restrictions, such as, focused review, mandatory prior authorizations for specified treatments or services, mandatory consultation, preceptorship, continuing medical education, closure of the Provider's practice to new Members, and/or imposition of a practice improvement plan.
 - b. Terminating the Provider's participation.
 - c. Imposing financial penalties such as an increased withhold, a one-time financial penalty (e.g. the cost of services incurred as a consequence of the Provider's non-compliance) or the denial of fees for inappropriate or unauthorized services.
4. Imposing a summary suspension. The Chief Medical Officer shall notify the Provider, by certified mail, of the summary suspension of the Provider's participation, if such action is necessary to protect Members' health and welfare or to protect the Plan's reputation or operations.
 - a. If the Chief Medical Officer or a Committee requires additional time to investigate allegations concerning a Provider's conduct, competence, practices or reputation, the summary suspension shall remain in effect pending the completion of that investigation. Such investigation must be completed within fourteen (14) days after the imposition of the summary suspension.
 - b. If, after such investigation, it is determined that the Provider's conduct, competence, practices or reputation may result in an imminent danger to Members' health or welfare, or impair the Plan's reputation or operations, the suspension shall continue in effect unless the Provider's participation is reinstated following a hearing conducted in accordance with section III, below.
 - c. The Chief Medical Officer shall make appropriate arrangements to have other Providers render services to Members who are under the care of the suspended Provider. The suspended Provider shall cooperate in referring Members to such other Providers in accordance with this Corrective Action Plan and the terms of his or her participation agreement.
 - d. If a Provider is a Member of a medical group or IPA, the Medical Director of that group or IPA shall be notified, in writing, of the imposition of corrective actions pursuant to this section.

D. ACTIONS BY THE COMMITTEE

1. Committee Meetings

If the Chief Medical Officer refers the matter to a Committee, that Committee shall consider information submitted to it concerning a Provider's non-compliance with the Plan's participation requirements during its next regularly scheduled meeting or at a special meeting called by the Chief Medical Officer to consider that matter.

Members of the Committee may participate in such meetings in person or by telephone conference call and may take actions by consent. Any meeting of a Committee concerning a Provider's alleged non-compliance shall be conducted in confidence and any information concerning such meetings shall be maintained as privileged and confidential information to the fullest extent permitted by applicable Peer Review Laws.

2. Committee Investigations

A Committee may direct the Chief Medical Officer or his designee to further investigate and submit additional information concerning a Provider's alleged non-compliance. The Committee may also request that the Provider submit specified information or attend a meeting to respond to questions concerning such alleged non-compliance. The Provider otherwise has no right to participate in Committee proceedings.

3. Corrective Actions

The Committee may request the Chief Medical Officer to take any of the corrective actions described in section II.C, above. In addition, the Committee may take any of the Corrective Actions described in section II. C. above except for II.C.4. (imposing a summary suspension). The Credentialing Committee may deny or revoke a Provider's Credentials.

E. NOTICE OF CORRECTIVE ACTION

The Chief Medical Officer or the Chairperson of the Committee shall immediately notify the Provider, by certified or overnight mail, of the imposition of a corrective action. If the Provider is a member of an IPA or medical group, a copy of that notice shall also be sent to the Medical Director of that IPA or medical group. That corrective action shall become effective as of the date of that letter, unless the Chief Medical Officer or Committee elect to defer the effective date of that action.

The notice letter shall include:

1. A description of the corrective action,
2. A general description of the basis of that action,
3. A statement explaining how to request an appeal to the imposition of that action (to the extent that action is subject to appeal), specifying that such an appeal must be requested within thirty (30) days after the date of that notice letter.
4. If applicable, a statement that the action may be reported to the State licensing board or other entities as mandated by law if the Provider doesn't request an appeal or if that action is affirmed following exhaustion of the appeal process.

III. APPEAL PROCEDURES

A. APPEAL OF NON-REPORTABLE ACTION BY A PARTICIPATING PROVIDER

1. Written Appeal
 - a. The Provider may appeal by submitting a written statement of his position within thirty (30) days of receipt of the notice of imposition of the corrective action. The written appeal will be reviewed by the Committee or Chief Medical Officer imposing the corrective action. A written response will be sent to the Provider within sixty (60) days of our receipt of the written appeal.
 - b. The Provider must comply with the terms and conditions of the corrective action while the appeal is pending, unless specifically directed otherwise by the Committee or Chief Medical Officer.
2. Informal Subcommittee Meeting
 - a. The Committee, in its sole discretion, may offer an informal subcommittee meeting to the Provider. The subcommittee will consist of individuals from the Committee and its purpose is to have an informal and open discussion with the Provider. The Provider has the option of accepting this offer for an informal subcommittee meeting, or may proceed to the next level of appeal as defined in this Section. The Provider does not waive any appeal rights by participating in the subcommittee meeting and may proceed with any appeals should the Committee uphold its decision after the subcommittee meeting.
 - b. If there is an informal subcommittee is granted, the Provider may not be represented by an attorney and the meeting shall not be tape recorded or recorded by a court reporter.
 - c. After the conclusion of the meeting, the subcommittee will make a recommendation to the appropriate Committee or the Chief Medical Officer concerning continued imposition of the corrective action. The subcommittee's recommendation will be considered at the next regularly scheduled Committee meeting unless the Chief Medical Officer calls a special meeting to consider that report. The Committee may accept, modify or reverse the subcommittee's recommendation, at its discretion. The Provider shall not have the right to appeal or to otherwise participate in the Committee's deliberations concerning the subcommittee's recommendation. The Committee shall notify the Provider of its decision within ten (10) working days after the date of that meeting.
3. Binding Arbitration
 - a. After the final decision by BCBST, all parties agree to take any dispute to binding arbitration. The Provider shall make a written demand that the adverse action be submitted to binding arbitration pursuant to the Commercial Arbitration Rules of the American Arbitration Association (current ed.). Either party may make a written demand for binding arbitration within thirty (30) days after it receives the Plan's response. The venue for the arbitration shall be in Chattanooga, TN unless otherwise agreed. The arbitration shall be conducted by a panel of three (3) qualified arbitrators, unless the parties otherwise agree. The arbitrators may sanction a party, including ruling in favor of the other party, if appropriate, if

- a party fails to comply with applicable procedures or deadlines established by those Arbitration Rules.
- b. The claimant shall pay the applicable filing fee established by the American Arbitration Association, but the filing fee may be reallocated or reassessed as part of an arbitration award either, in whole or in part, at the discretion of the arbitrator/arbitration panel if the claimant prevails upon the merits. If the claimant withdraws its demand for arbitration, then claimant forfeits its filing fee and it may not be assessed against BCBST.
 - c. Each party shall be responsible for one-half of the arbitration agency's administrative fee, the arbitrators' fees and other expenses directly related to conducting that arbitration. Each party shall otherwise be solely responsible for any other expenses incurred in preparing for or participating in the arbitration process, including that party's attorney's fees.
 - d. The arbitrators: shall be required to issue a reasoned written decision explaining the basis of their decision and the manner of calculating any award; shall limit review to whether or not the Plan's action was arbitrary and capricious; may not award punitive or exemplary damages; may not vary or disregard the terms of the Provider's participation agreement, the certificate of coverage and other agreements, if applicable; and shall be bound by controlling law; when issuing a decision concerning the matter at issue. Emergency relief such as injunctive relief may be awarded by an arbitrator/arbitration panel. A party shall make application for any such relief pursuant to the Optional Rules for Emergency Measures of Protection of the American Arbitration Association (most recent edition). The arbitrators' award, order or judgment shall be final and binding upon the parties. That decision may be entered and enforced in any state or federal court of competent jurisdiction. The arbitration award may only be modified, corrected or vacated for the reasons set forth in the United States Arbitration Act (9 USC § 1).
 - e. This arbitration provision supersedes any prior arbitration clause or provision contained in any other document. This arbitration clause may be modified or amended by BCBST and the Provider will receive notice of any modifications through updates to the Provider Manual.

B. APPEAL OF NON-REPORTABLE ACTION BY AN APPLICANT

- 1. Written Appeal
 - a. The Provider may appeal by submitting a written statement of his position within thirty (30) days of receipt of the notice of the denial of application. The written appeal will be reviewed by the Committee or Chief Medical Officer. A written response will be sent to the Provider within sixty (60) days of our receipt of the written appeal.
- 2. Binding Arbitration
 - a. If the Provider is still not satisfied with the Committee's decision, he may make a written request that the matter be submitted to binding arbitration in accordance with the procedure set forth in section III.A.3 above.

C. APPEAL OF A POTENTIALLY REPORTABLE ACTION BY PARTICIPATING PROVIDERS OR APPLICANTS

1. Informal Subcommittee Meeting

- a. The Committee, in its sole discretion, may offer an informal subcommittee meeting to the Provider. The subcommittee will consist of individuals from the Committee and its purpose is to have an informal and open discussion with the Provider. The Provider has the option of accepting this offer for an informal subcommittee meeting, or may proceed to the next level of appeal as defined in this Section. The Provider does not waive any appeal rights by participating in the subcommittee meeting and may proceed with any appeals should the Committee uphold its decision after the subcommittee meeting.
- b. If the informal subcommittee is granted, the Provider may not be represented by an attorney and the meeting shall not be tape recorded or recorded by a court reporter.
- c. After the conclusion of the meeting, the subcommittee will make a recommendation to the appropriate Committee or the Chief Medical Officer concerning continued imposition of the corrective action. The subcommittee's recommendation will be considered at the next regularly scheduled Committee meeting unless the Chief Medical Officer calls a special meeting to consider that report. The Committee may accept, modify or reverse the subcommittee's recommendation, at its discretion. The Provider shall not have the right to appeal or to otherwise participate in the Committee's deliberations concerning the subcommittee's recommendation. The Committee shall notify the Provider of its decision within ten (10) working days after the date of that meeting.

2. Hearing

a. Appointment of the Hearing Officer

The Provider may request a hearing regardless of whether or not there was an informal subcommittee meeting. In that event, the Chief Medical Officer shall appoint a qualified designee to serve as the Hearing Officer within thirty (30) working days after receiving that request. The Hearing Officer:

1. Shall not receive a financial benefit from the outcome of the hearing and shall not act as a prosecutor or advocate for the Plan.
2. May not be in direct economic competition with the Provider requesting the hearing.
3. Must be qualified to evaluate the issues likely to be presented during the hearing.
4. Shall be acting as member of the Committee while performing his or her duties.

b. Notice of Hearing

The Hearing Officer will contact the Provider to establish a mutually acceptable date, time, and place for the hearing; which shall be conducted not less than thirty (30) days after that date. The formal hearing shall be conducted within 120 days of appointment of the Hearing Officer unless both parties agree to extend this time limit. If the parties are unable to agree, the Hearing Officer shall schedule

the hearing. The Hearing Officer shall then issue a written notice of hearing to the Provider summarizing: 1) the scheduled time, date and place where the hearing will be conducted; 2) the applicable hearing procedure; 3) a detailed description of the basis of the corrective action, including any acts or omissions which the Provider is alleged to have committed (the "Allegations"); and 4) a statement concerning whether that action may be reportable to the State licensing agency or other entities as mandated by law in accordance with applicable Peer Review Laws.

c. Hearing Procedure

The hearing will be an informal proceeding. Formal rules of evidence or legal procedure will not be applicable during the hearing. The Hearing Officer may reschedule or continue the hearing at his or her discretion or upon reasonable request of the parties. The Provider may forfeit the right to a hearing; however, if he or she fails to appear at the hearing without good cause, the right to schedule another hearing is also forfeited. In addition to any procedure adopted by the Hearing Officer:

1. The Provider has the right to be represented by an attorney or other representative. If the Provider elects to be represented, such representation shall be at his or her own expense.
2. The hearing will be recorded by a court reporter.
3. The Provider and the Plan must provide the other party with a list of witnesses expected to testify on its behalf during the hearing and any documentary evidence that it expects to present during the hearing, as soon as possible following issuance of the notice of hearing. Either party may amend that list at any time not less than ten (10) working days before the date of the hearing.
4. Each party has the right to inspect and copy any documentary information that the other party intends to present during the hearing, at the inspecting party's expense, upon reasonable advance notice, at the location where such records are maintained.
5. During the hearing, each party has the right to:
 - i. call witnesses,
 - ii. cross-examine opposing witnesses, and
 - iii. submit a written statement at the close of the hearings.
6. Following the hearing, each party may obtain copies of the record of the hearing, upon payment of the charges for that record. Each party shall also receive a copy of the Hearing Officer's report and recommendation.

d. Hearing Officer's Report

The Hearing Officer will issue a written report and recommendation within thirty (30) days after the conclusion of

the hearing. That written report will set forth the Hearing Officer's recommendation concerning the imposition of the corrective action, if any, and the basis for that recommendation.

e. Action by the Committee

The Hearing Officer's report will be submitted to the appropriate Committee for consideration during its next regularly scheduled meeting, unless the Chief Medical Officer calls a special meeting to consider that report. The Committee may accept, modify or reverse the Hearing Officer's recommendation, at its discretion. The Provider shall not have the right to appeal or to otherwise participate in the Committee's deliberations concerning the Hearing Officer's report. The Committee shall notify the Provider of its decision within ten (10) working days after the date of that meeting. The committee's decision is the final internal action by BCBST. In the event the decision is an adverse decision as defined by applicable federal and/or state laws, BCBST will report to the appropriate agencies or Boards as required by the applicable federal or state laws.

f. Appeal of Decision

Any action based upon or related to the Committee's decision must be submitted to binding arbitration in accordance with paragraph III.A.3 above.

IV. REPORTING CORRECTIVE ACTIONS

A. REPORTING TO REGULATORY AGENCIES

Certain actions must be reported in accordance with both state and federal law, including without limitation, the Healthcare Integrity and Protection Data Bank (HIPDB). The Chief Medical Officer will consult with the Plan's General Counsel prior to initiating any corrective action, if there is a question concerning whether it will be a reportable action.

1. The following actions must generally be reported:

- a. All professional review actions adversely affecting a Provider's participation in the Plan for longer than thirty (30) days based upon the Provider's professional conduct or competence.
- b. Acceptance of a voluntary termination of the Provider's participation while the Plan is investigating the Provider's conduct or competence, if that termination is intended to avoid the imposition of reportable sanctions.
- c. A summary suspension that remains in effect for longer than fourteen (14) days.

2. Reports required by federal or state law, including without limitation the HIPDB, must include:

- a. the name of the Provider,
- b. a description of the facts and circumstances that form the basis for that action, and
- c. any other relevant information requested by that licensing board.

3. The following actions are generally not reportable:
 - a. Actions that do not adversely affect the Provider's participation for longer than thirty (30) days.
 - b. Actions based upon the Provider's failure to comply with participation requirements that are not directly related to the Provider's professional conduct or competence.

B. INTERNAL REPORTING REQUIREMENTS

All corrective actions whether reportable to a licensing board or not, must be reported to the following persons:

1. The involved Provider.
2. The Plan's General Counsel.
3. The Plan's Provider Networks and Contracting Department.
4. The Medical Director of each participating Medical Group or IPA if the Provider is a member of that entity.