I. SCOPE

This policy applies to (1) Canopy Health, LLC ("Canopy Health") and its subsidiaries and affiliates (each, an "Affiliate"); and (2) any other entity or organization with which Canopy Health contracts for such entity or organization to perform provider credentialing on Canopy Health's behalf (each a "Contractor"). To the extent that any Contractors perform functions set forth herein, references to "Canopy Health" or the "Credentialing Department" shall be interpreted to refer to such Contractors.

II. PURPOSE

The purpose of this policy is to provide a mechanism for review of practitioners for any reason, including but not limited to patient or health plan complaints, quality or utilization data, malpractice litigation, state licensing board action.

III. DEFINITIONS

Credentialing Peer Review Committee: A group of providers selected by Canopy Health that evaluate the qualifications and make the final determination regarding the status of providers applying for participation in Canopy Health's network, and evaluate the necessity, quality or utilization of care rendered by providers in the network.

Participating Provider: Any practitioner or organization that is contracted or employed by Canopy Health to render services to members.

IV. POLICY

A. A practitioner's status may be reduced, suspended or terminated for any lawful reason, including but not limited to:
   1. A lapse in basic qualifications such as licensure, insurance, board certification or required medical staff membership or privileges at a specified hospital
   2. A determination that the practitioner cannot be relied upon to deliver the quality or efficiency of patient care desired by the network
   3. A determination that the practitioner cannot be relied upon to follow the network's clinical or business guidelines or directives
   4. A change in the network's business needs.

B. When Canopy Health decides to suspend, non-renew, or terminate a provider's participation in its network, it must furnish written notice to the affected provider with the reason for the decision.

C. If a practitioner receives an adverse decision which entitles the practitioner to a hearing, then that practitioner shall not be eligible to reapply until one (1) year after

the adverse decision is final and the practitioner has exhausted all applicable hearing rights; the practitioner must undergo the initial credentialing process if the break in service is greater than 30 days. The credentials of the practitioner will be re-verified following the same guidelines as described in CD1003; it is not required to re-verify credentials that do not expire, such as, completion of education and training and board certification that is not time-limited.

V. PROCEDURE

A. Issues raised about a practitioner's performance shall be considered initially by the Medical Director, who shall have the broad discretion to determine how to proceed as delegated by the CPRC.
   1. The Medical Director's options include but are not limited to:
      a. Maintaining a record of the matter without further investigation or action
      b. Investigating the matter personally and making a report and recommendation to the CPRC as warranted
      c. Referring the matter to the CPRC for investigation and the determination on how to proceed

B. In instances where there may be an imminent danger to the health of any individual, the Medical Director may summarily reduce or suspend the practitioner's privilege to provide patient care services; this will be effective immediately upon notice to the practitioner and remain in effect until further consideration and action by the Credentialing or Quality Management Committee is taken.
   1. The CPRC can elect to perpetuate the reduction or suspension pending action by the network.

C. The practitioner shall be sent a written statement by certified mail of the issues or concerns and afforded 30 days to address them in writing or at a meeting.

D. Upon receipt of a response, the CPRC will review and recommend an action.

E. A copy of the report and recommendation shall be sent to the practitioner at the same time it is submitted to the CPRC by the QMC or CD. The practitioner shall be allowed 10 days from receipt of the report and recommendation within which to request of the Medical Director, in writing, that appellate review be conducted by the network.
   1. The grounds for the request shall be clearly stated.
   2. The network shall not take action on the matter during this 10 day period.

3. If the appellate review is not requested within the time and in the manner specified, the network shall take such final action as it deems appropriate and announce it in writing to the Medical Director, the Credentialing Committee, and the practitioner.
4. If appellate review is requested within the time and in the manner specified, the CPRC shall arrange for the review to be conducted as soon as practicable.
5. The appellate review shall include, at least, an opportunity for the Medical Director or the CPRC and the practitioner to present relevant information and arguments in writing or orally.
6. The network shall have the discretion to prescribe such additional procedural elements, as it deems appropriate to the circumstances.
7. When the CPRC is satisfied that sufficient information and arguments have been presented in the appellate process, it shall take such final action, as it deems appropriate and announce it in writing to the Medical Director and the practitioner.

F. The CPRC will provide written notification to the practitioner of the appeal decision that contains the specific reasons for the decision which may include, but are not limited to the following:
   1. Medical disciplinary cause or reason, meaning an aspect of a practitioner's competence or professional conduct which is reasonably likely to be detrimental to member safety or to the delivery of patient care
   2. Conduct or professional competence of a practitioner which affects or could affect adversely the health or welfare of a member

G. The network shall comply with the reporting requirements of the appropriate licensing board and the National Practitioner Data Bank, within 30 days of the final decision as required by law.

H. The network shall comply with the reporting requirements of the California Business and Professional Code (805) within 15 days of the final decision.

I. The network shall comply with the reporting requirements of the Federal Health Care Quality Improvement Act regarding adverse credentialing and peer review actions.

J. All 805 and NPDB reporting will be submitted by the Medical Director.

K. The practitioner will be notified of the report and its contents.

L. The health plans will be notified of the outcome/reports.

VI. ENFORCEMENT

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

VII. REFERENCES

A. NCQA – CR 6

REVISION HISTORY:

Version Date	Edited By	Reason for Change
01/01/2017	**M. Durbin**	**Created policy**
11/13/2018	**R. Scott**	**Updated for NCQA Requirements**
01/01/2019	**R. Scott**	**Updated to correctly reference NCQA CR 6 standard rather than 7.**