



Provider Manual

Provider Relations Section

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PROVIDER RELATIONS

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GENERAL POLICY & PROCEDURES

Overview

New Avenues has established guidelines for contracted providers. These guidelines include the policies and procedures, rights and responsibilities, clinical and administrative processes for New Avenues. New Avenues reserves the right to limited credentialing only those providers that practice in a region that represents active member enrollment. To ensure an understanding of these guidelines and to create a mutually satisfying relationship with our providers, this manual will cover:

- Practice Eligibility Requirements
- Standards for Availability to Members in an Emergency
- Provider Qualifications by Specialty
- Credentialing Application and Documentation Requirements
- Facility Credentialing
- Provider Practice Update
- Re-Credentialing Process and Notification
- Provider Dispute Resolution
- Medical Record Standards
- Confidentiality
- Providers Rights

General Policy and Procedures

- Providers cannot bill members except for co-payments, deductibles, coinsurance and non-covered services.
- Provider cannot bill for the difference between the New Avenues' contracted fee and the provider's charge amount. Additionally, the member must not be billed for any pre-certification penalty the provider may have incurred.
- Providers must not bill members for services that would have been paid by New Avenues when the provider failed to follow the requirements of their agreement.
- Providers must comply with medical management and clinical documentation requirements.
- Providers must ensure confidentiality of member information
- Provider must give timely notice, as stated in their contract, prior to termination of privileges.
- Provider will notify New Avenues immediately of any changes in information supplied to New Avenues as part of the application process.
- Provider will provide equal treatment to all members.
- Provider will submit all claims for payment within the timeframe specified in their contract.
- Providers must notify New Avenues immediately of any changes in information supplied to New Avenues as part of the application process for participation.
- Provider will comply with all applicable requirements of the law and regulations related to medical and health care services to the public.
- Providers will submit all billing using the CMS/1500 or UB92 forms.

CREENTIALING & RE-CREDENTIALING PROCESS

Practice Eligibility Requirements

A provider is eligible for participation with New Avenues, Inc. and applicable sponsored networks if all of the following eligibility requirements are met:

1. Provider provides behavioral healthcare services as are required by the New Avenues member population and/or benefit plans and are within the professional standards of their respective professions' scope of practice.
2. Provider demonstrates a willingness to provide care within the guidelines of the New Avenues, Inc. Utilization Management Programs as well as fulfill case documentation requirements as specified in the Provider Agreement.
3. Provider must have adequate telephonic accessibility within one-business day. Provider must maintain telephone coverage to answer calls, have a secretary, and/or answering service, pager service, or an answering machine so as to conduct business within 24 business hours; description of the New Avenues, Inc. standards for the providers' responsibilities to members in event of emergency in non- business hours is described below.
4. Provider must have the ability to send and receive confidential faxes to a fax located within the provider's confidential office setting. Providers sharing office space in a multi-use business setting must demonstrate privacy of fax communications. If provider is using a fax machine located at a home office, the fax machine must be located in a separate non-public area of the home not accessible by family or guest visiting the home to ensure member confidentiality.
5. The provider must be available for arranging appointments within business hours between the hours of 8:00am-8:00pm within the following access standards: Routine Care-10 Business Days, Urgent Care-48 hours, Emergent (Non life threatening)-6 hours.
6. Provider must practice a minimum of 15 hours per week for seeing patients, and able to accept at least 3-5 patient referrals a month. A provider that declines more than 50% referrals in a year, shall be subject to termination of participation unless there are extenuating circumstances.
7. Provider must maintain the appropriate current, valid and unrestricted professional licensure to practice for his/her professional discipline in the state in which Provider will treat members.
8. Provider must maintain malpractice insurance with a minimum coverage amount of \$1,000,000 per occurrence \$3,000,000 aggregate, and/or participation in the Indiana Patient Compensation Fund or Federal Torts Claim Act (FTCA).
9. If the provider is employed in a facility or program, that facility or organization must also be approved for participation in the Network.

10. Prior to acceptance for network inclusion, site visits to the offices of potential high volume behavioral healthcare providers, clinics, or facilities are conducted according to the review standards established by New Avenues. A major focus of such site visits is to evaluate the record keeping practices of the provider or facility vis-a-vis the standards established by the New Avenues.

Standards for Provider Availability to Members in Event of Emergency

New Avenues, Inc. has standards that members have access to a provider in the event of an emergency during non-business hours or during the absence of their provider from his /her practice, and requires that providers inform patients about their availability for emergencies. Therefore, New Avenues has established the requirement that each professional, during the credentialing process, provide New Avenues a description of the provider's plan for response to psychiatric emergencies during non-business hours. This requires that providers meet one of the following criteria (Note Standards listed below for psychiatrists):

- Provider has an answering service that will notify the provider and direct calls to the provider or designated substitute in event of emergency;
- Provider has a system for sharing "on-call" coverage for his/her practice;
- Provider carries a pager or has some telephonic system that can alert him/her to a member's needs;
- Provider has an answering machine with a message that directs a patient to an appropriate level of care, specifically – such as another provider, an access center of an agency or hospital;
- Provider is part of an agency, hospital or facility that provides 24 hour emergency access; or
- If Provider is in private practice setting, and does not have one of the above services, the Provider will show documentation in the patient record that an Emergency Response Policy has been given to the patient which outlines what procedure to follow in event of an emergency and the patient has by signature indicated that he or she has been informed of what to do. This may be documented through the provider furnishing a copy of their office policy on Procedures to Follow in Event of Emergency with a signature line;

Psychiatrists must provide additional evidence that they have a specific plan for patients to use in event of an emergency. This information must give the patient in acute distress access to the provider himself/herself, to another person on call, or to an Access Center (if employed by or with privileges at an agency or hospital). Merely having a phone message directing a member to a near-by hospital is not adequate for meeting this standard for participating Network psychiatrists. Availability for prescription refills is not ordinarily considered a medical emergency; and thereby not subject to the same need for access for non-business hours availability.

PROVIDER QUALIFICATIONS BY SPECIALTY

Psychiatrists MD/DO

1. Have a current, valid and unrestricted professional license issued by a state-licensing agency in the United States for each state in which he or she will treat members.
2. Must be Board Certified or Board Eligible
3. Current, valid CRS
4. Current, valid DEA certificate
5. Graduation from medical school
6. Completion of residency training in psychiatry,
7. Listing of any clinical privileges with hospital(s) for which the provider may be active
8. Evidence of emergency access to members.

Addictionologists, MD/DO

1. Must have a current, valid and unrestricted professional license issued by a state-licensing agency in the United States for each state in which he/she will treat members.
2. Current, valid CRS
3. Current, valid DEA certificate
4. Graduation from Medical School
5. Completion of residency training program
6. Must be Board Certified by the American Board of Psychiatry and Neurology with added qualifications in Addiction Psychiatry and or;
7. Completion of certification from the ASAM, American Society of Addiction Medicine
8. Must have worked in this specialized field for at least five years and their scope of practice is limited to the assessment and management of substance abuse and compulsive disorders.
9. Listing of any clinical privileges with hospital(s) for which the provider may be active
10. Evidence of emergency access to members

Advanced Nurse Practitioners, Clinical Nurse Specialist

1. Must have a current, valid and unrestricted professional license issued by a state-licensing agency in the United States for each state in which he or she will treat members.
2. Completion of a nurse practitioners Masters Degree in a nursing program in the specialty area of psychiatry or;
 - a. Completion of a formal post-graduate (Masters Degree) in a nurse practitioner track or program within a school of nursing granting graduate level academic credit from one of the following specialty areas of family medicine, adult or pediatrics with 5 years of experience in a behavioral health setting or;
 - b. from a track or program specializing in psychiatry/behavioral health. Evidence of successful completion will be a certificate or a letter from the program director. The educational program that has prepared the nurse practitioner must have included both didactic and clinical components.
3. Current, valid CRS
4. Current, valid DEA certificate
5. Experience in behavioral health settings for at least 3 years if Master's Degree was achieved in psychiatry/mental health; (or 5 years experience if the master's degree was attained in adult, pediatric, or family advance nursing program but not specific to behavioral health);

6. Written evidence is submitted at the time of application of credentialing which shows that the collaborating and supervising psychiatrist a) assumes responsibility for supervision and monitoring the ANP's practice, b) is available (or will provide an alternate to provide) consultation on the premises when requested and to intervene when necessary, c) will assume responsibility for the care of any patient being assessed or treated by the ANP upon request, as required by the scope of practice listed below, or when it is in the best interest of the patient; and d) will review charts, medications, and treatment plans in cooperation with New Avenues standards.
7. Practice setting is in the same office, hospital, or agency as the collaborating/supervising psychiatrist.
8. Collaborating/supervising psychiatrist is credentialed and in good standing by New Avenues, Inc.

Psychologists Ph.D./Psy.D.

1. Must have a current, valid and unrestricted professional license issued by a state-licensing agency in the United States for each state in which he or she will treat members.
2. Certified as a Health Services Provider in Psychology (HSPP), if in independent private practice.
3. Graduation from a professional school of Psychology earning a degree in a doctoral program in Psychology.

Masters-Level Professionals, LCSW, LMFT, LMHC

1. Must have a current, valid and unrestricted professional license issued by a state-licensing agency in the United States for each state in which he or she will treat members.
2. Graduation from a professional school earning a Master's level degree in Social Work, Counseling Program or a related field that meets state licensure requirements to conduct diagnosis and treatment on an independent basis.

Certified Addiction Professionals, CADAC I/II, NAADAC I/II

1. Must be employed and working within an accredited facility. New Avenues recognizes the following accrediting organizations:
 - 1.1 JCAHO, Joint Commission on the Accreditation of Healthcare Organizations,
 - 1.2 CARF, Commission on Accreditation of Facilities for Families and Children,
 - 1.3 COA, Council on Accreditation of Facilities for Families and Children,
 - 1.4 ACACAC, American Corrections Association Commission on Accreditation,
 - 1.5 NCQA, National Committee of Quality Assurance,
 - 1.6 AAAHC, Accreditation Association for Ambulatory Health Care,
 - 1.7 URAC, Utilization Review Accreditation Commission,
 - 1.8 MQC Medical Quality Commission.
2. Practice is limited to the assessment and treatment of primary substance abuse and chemical dependency disorder.
3. Must have a Bachelor's or Master's level degree
4. Must be certified CADAC I/II or NAADAC I/II
5. Must have supervisory agreement; supervisor must be a licensed Master's level, Ph.d. or physician with substance abuse credentials.

CREDENTIALING APPLICATION AND DOCUMENTATION REQUIREMENTS

All participating providers are required to be credentialed. New Avenues credentials providers according to NCQA, National Committee for Quality Assurance standards. To be considered for credentialing, all providers must complete and submit a credentialing application. The credentialing application is divided into two parts: Part I, The Provider Inquiry Response Form and Part II, the CAQH, Counsel for Affordable Quality Healthcare application form. The following documentation will be required to complete the manual credentialing process:

- Provider Inquiry Response Part I;
- CAQH Provider Application Part II; www.cagh.org/credapp/
- Signed and dated Release of Information and Attestation;
- W-9 Tax identification form;
- Copy of valid and current unrestricted license to practice within the state the provider will be seeing members;
- Copy of valid current and unrestricted state Controlled Substance Registration Certificate for each state in which the provider will treat members, if applicable, Physicians, and Nurse Practitioners only.
- Copy of valid current and unrestricted federal Drug Enforcement Registrations, DEA, if applicable, Physicians and Nurse Practitioners;
- Work history, Curriculum Vita must indicate by the beginning and ending month and year a minimum of five years of work history. The provider must clarify with verbal or written explanation of any gaps in work history of 6 months or more;
- Proof of graduation, copy of degree, the highest degree pertaining to licensure;
- Evidence of Board Certification, or letter of board eligibility, if applicable;
- Copy malpractice face sheet documenting the dates and amounts of current, valid and adequate malpractice insurance, minimum coverage amounts of \$1,000,000 per occurrence \$3,000,000 aggregate, and/or participation in the Patient Compensation Fund; or are individuals covered by the Federal Torts Claim Act (FTCA)
- A complete history of professional malpractice/liability claim action, pending, settled, dropped, dismissed, arbitrated, mediated or litigated.

Provider's Not Requiring Credentialing

- A Provider who practices exclusively within an inpatient setting and who provides care for members as a result of the member being directed to the hospital or inpatient setting.
- Locum Tenens.
- Out of network providers that meet all specialty and eligibility requirements that may see a member due to geographic location out of area, behavioral specialty not already represented in the network, or to accommodate language or members special needs as determined by a New Avenues Care Manager. New Avenues will contract services under a case specific Letter of Agreement with that provider.

New Avenues will notify the provider concerning the status of the provider's credentialing application no later than sixty (60) days after New Avenues receives the completed credentialing application form Parts I & II; and every thirty (30) days after the first notice, until the New Avenues Credentialing Committee has made a final determination on the applicants privileges.

FACILITY CREDENTIALING

New Avenues facility eligibility criteria, programs that are considered as facility-based programs are:

- Inpatient facilities providing acute care;
- Partial Hospitalization;
- Intensive Outpatient Programs specialized for treatment of addictions, psychiatric, dual-diagnosis, or eating disorders;
- Sub- Acute Care;
- Detoxification Treatment Programs
- Residential Treatment Centers (Typically not contracted with)

Treatment programs listed above as providing covered services may be offered in a community hospital, tertiary level hospitals, community mental health centers, addiction clinics, or freestanding behavioral health organizations. The credentialing determination is based on the qualifications, licensure, and accreditation standing of the program and/or facility.

Facility Eligibility Criteria

New Avenues criteria for participation in the facility network include:

1. Must be state license, if applicable in the jurisdiction where the facility is located, which designates the facility as a treatment facility.
2. Confirmation that the facility is in good standing with state and federal regulatory bodies.
3. Liability (malpractice) insurance in accordance with established amounts indicated in the facility agreement.
4. Accreditation by an accrediting organization recognized by New Avenues. New Avenues recognizes the following accrediting organizations:
 - The Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
 - The Commission on Accreditation of Services for Families and Children (CARF).
 - The Council on Accreditation of Services for Families and Children, Inc. (COA).

New Avenues does not contract with non-accredited facilities.

Delegated Credentialing

Currently New Avenues does not offer any delegated credentialing privilege. All clinicians providing outpatient services requires individual credentialing by New Avenues.

Provider and Practice Updates

New Avenues requires immediate notification of any changes in information supplied as part of the initial application process. This information includes, but is not limited to changes, terminations or additions of:

- Address-Clinical, Billing, & Correspondence
- Phone/Fax number
- Name

- Tax Identification
- Practice Panel Status (open/closed)

Updating this information promptly will help New Avenues timely communicate information including, claims payment, correspondence, directory and website listings and member selection.

Provider should submit updates and changes on the New Avenues Provider Update Form. You can access this form via our website at www.NewAvenuesOnline.com, in the Provider Desk section.

RE-CREDENTIALING PROCESS AND NOTIFICATION

New Avenues re-credentials individual providers on a 36-month cycle, during the re-credentialing cycle, approximately 90-180 days prior to the due date, New Avenues will mail a re-credentialing application to the provider requesting updated practice information.

A provider is eligible for continuation participation in the New Avenues networks if the provider has maintained continued compliance with all of the eligibility requirements as outlined in the credentialing section listed above, which are defined into the following sections:

- Practice Eligibility Requirements
- Standards for Provider Availability to Members in Event of Emergency
- Provider Qualifications by Specialty

If New Avenues cannot obtain the necessary re-credentialing information for reasons beyond its control, i.e. provider is on active military assignment, medical, maternity leave or sabbatical, but the contract between New Avenues and the provider remains in place, New Avenues may re-credential the practitioner upon his/her return. New Avenues must document the reason for the delay in the provider's credentialing file. New Avenues must verify that a provider who returns from medical, maternity or sabbatical leave has a valid license to practice before he/she resumes seeing patients and notes the date in the file. Within 60 days of when the provider resumes practice New Avenues must complete the re-credentialing cycle. If either party terminates the contract and there is a break in service more than 30 days, the provider must go through the complete initial credentialing process before he/she rejoins the network.

PROVIDER DISPUTE RESOLUTION

Provider Dispute is the first written communication, facsimile or e-mail, by a provider, primarily indicating disagreement or expressing dissatisfaction with an administrative decision. An administrative decision may include:

- **Payment Dispute:** a dispute challenging or seeking reconsideration of a billing or payment determination, a request for reimbursement of an overpayment of a claim, or a claim that has been denied, adjusted or contested, including clinical denials.
- **Contractual Dispute:** a dispute concerning a term or provision of the provider's contract or any matter pertaining to the contractual relationship between a provider

and New Avenues, Inc. Such disputes shall be resolved in accordance with the Provider's contract.

- **Operational Dispute:** a dispute regarding any aspect of New Avenues, Inc. management or operations, including but not limited to New Avenues, Inc. policies and procedures.
- **Network Termination Dispute:** a dispute regarding a provider's termination from the network, with or with cause.
- **Provider Inquiry:** a communication by or on behalf of a provider requesting information, an explanation, or clarification from New Avenues. An inquiry is a communication that does not rise to the level of dispute. The nature of an inquiry means that the issue is oftentimes resolved upon initial contact with New Avenues.
- **Provider Appeal:** any written expression of dissatisfaction or disagreement by a provider following an adverse decision of a Provider Dispute and a desire to appeal the dispute to the next level, if permitted by New Avenues, Inc. or applicable law. It includes any appeal that does not involve medical necessity review.

Requirements of Submission of Dispute

Providers should include the following on their dispute in order for New Avenues to handle the inquiry most efficiently:

- Detailed description of the dispute, including basis upon which provider believes the payment amount, request for additional information, request for reimbursement of overpayment of claim, claim payment, or other action is incorrect.
- A clear explanation of a non-claim dispute, including the contractual basis on which the provider is basing the dispute, and the provider's position thereon.
- Member identification number
- Patient's first and last name
- Patient's date of birth
- Date of service
- Provider name
- Provider contact information

If a dispute is filed and a required element is missing or unclear, New Avenues has the right to return the dispute to the provider within 45 days and request the provider resubmit with additional information within 30 days, or the dispute may be closed.

Time Period for Submission and Response of Disputes

Providers must submit disputes to New Avenues within 90 days of the last action taken on the claim in question. Submissions after 90 days of this date will be issued a denial for untimely filing.

New Avenues will acknowledge receipt of the dispute within 15 days of receipt of a paper submission. New Avenues will respond to provider with a written determination within 45 days of receipt of issue.

MEDICAL RECORD STANDARDS

The medical record is an important source of vital patient information and must be complete and up-to-date to assure continuity of care. Each network practitioner should have a system for maintenance, storage and retrieval of records in addition to the protection against unauthorized use.

New Avenues has established standards for the structural integrity of medical records. Medical records documentation will be evaluated periodically for compliance with New Avenues current standards to validate the following service expectation. Medical records must:

- Be maintained consistently, one for each member.
- Be kept current, complete, organized and legible.
- All entries are dated.
- Contain the member's name and ID number on each page.
- Contain personal biographical data including address, employer, home and work telephone numbers and marital status.
- Include consent for treatment and release of information forms.
- Contain list of significant illnesses and medical conditions (problem list)
- Medications prescribed with dosages.
- Note allergies and adverse reactions to medication, or lack of known allergies, NKA.
- Contain past psychiatric treatment history.
- Includes a GAF Score, Axis information and diagnoses.

Documentation must also include

- Diagnoses that are consistent with findings.
 - Treatment plans that are consistent with the diagnoses.
 - Treatment intervention coincides with the treatment plan goals and objectives.
 - Progress notes describe the patient's strengths, and limitations related to achieving treatment goals and objective.
 - Documentation that the member understands and agrees with the treatment plans.
 - Documentation that the PCP was notified of hospitalization, treatment, or medications, with a release on file.
 - Medical conditions are prominently identified and updated when changes occur.
 - Notation concerning the use of cigarettes, alcohol and substances, when appropriate.
 - Patients that are homicidal, suicidal, high risk, or any other type of special situation are prominently documented with appropriate treatment plans.
 - Preventative services used are documented. (As appropriate)
 - Continuity of care and evidence of follow-up dates or discharge plan and closing summary exist.
 - Evidence of laboratory, psychological testing and other diagnostic studies ordered as appropriate.
 - The provider's identification (signature, unique electronic identifier, or initials) and date on all entries in the medical record.
- No evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.

Confidentiality

Confidentiality is critical to New Avenues and is expected throughout its contracted provider network. Confidential information is shared only with those entities who have authority to receive such information.

Provider agrees to treat member records as confidential and to comply with all federal and state confidentiality laws. Behavioral health providers are required to share only member approved information with the member's primary care practitioner. Due to the business arrangement between New Avenues Inc. and our participating providers, member consent to release medical records is not necessary.

Member and provider specific data include medical records received by New Avenues are kept confidential in accordance with applicable laws. Information received by New Avenues is used solely for the purpose of utilization management, quality management, disease management, discharge planning, case management, claims payment, peer review, investigation of complaints, grievances or quality of care issues, or determining the content and quality of medical records documentation. New Avenues is in compliance with the HIPAA regulations.

PROVIDER RIGHTS AS THEY APPLY TO CREDENTIALING & RE-CREDENTIALING

Provider Rights As They Apply To Credentialing & Re-Credentialing:

Provider Applicants have the right to:

1. A written description of the New Avenues requirements for credentialing, and terms and conditions for contracting with the New Avenues (including fee schedule) to determine if the applicant wants to participate in the New Avenues Network;
2. A written description of the application process; including being sent a Provider Inquiry Response Part 1 form within 30 days of the receipt of their application inquiry.
3. New Avenues shall notify the provider concerning the status of the provider's completed credentialing application no later than sixty (60) days after New Avenues receives the completed credentialing application for, and every (30) days after the first notice until Credentialing Committee makes their determination concerning the provider.
4. A timely application and re-application decision process, which is no longer than 180 days from the date of the Attestation. The provider also is entitled to a written decision of the Credentialing Committee within 30 days of the Committee review of the completed application. The Provider Relations Department will send a letter notifying the provider of the committee's review and approval to the network.
5. An opportunity to appeal the decision, in the event of a Credentialing Committee decision to not approve an application for credentialing or re-credentialing. The Provider Relations Department will send a letter notifying the provider of the committee's review and denial to the network within 30 days. In addition to the network denial notification, the provider will also receive a copy of the Provider

Rights and Appeal Information Handout given them instructions and procedures on how to appeal the committee's decision.

6. In the event the Credentialing Committee would pend an application for clarification or additional information, at the initial credentialing or re-credentialing, New Avenue's time limit of 180 days from the Attestation date still apply. If the provider fails to respond to the New Avenues request for additional information or clarification within 30 days of receipt of requested information, the application will be presented to the credentialing committee as incomplete and the credentialing process will be terminated, such timeframe and termination will be documented in the letter requested information.
7. In the event that a Provider wishes to appeal a decision, the provider has the right to notification about the appeal process. The written procedures for appeal is for the provider to submit in writing directed to the Provider Relations Department a request for re-consideration of a credentialing or re-credentialing decision within thirty (30) days of receipt of the New Avenues Credentialing Committee decision.
8. The provider has a right to review information submitted to support their credentialing and re-credentialing application, including the right to review copies of materials or documents that were used in making a decision about the provider's qualifications, and a right to present additional, substantive information for re-consideration. However, New Avenues does not reveal references or recommendations or other information that is peer review protected. It also does not provide NPDB information. The provider may query the NPDB himself or herself; the New Avenues may indicate to the provider that information obtained from the NPDB was inconsistent with the applicant's information; however, the New Avenues will not reveal information obtained from the NPDB.
9. It is the applicant's responsibility to submit additional information to correct or clarify the point of error or inaccuracy in information obtained in the credentialing or re-credentialing process. Notification of the right to correct erroneous information is documented on the Provider Inquiry Response Form, Part I. If during the credentialing or re-credentialing process erroneous information is detected, the Provider Relations Department will notify the provider in writing giving a detailed description of the inconsistent or erroneous information and request corrective information or documentation by the provider. In the event that the provider does not provide corrective or additional information within 30 days from the date of the notification letter, the provider's initial application will be considered incomplete and the credentialing process will be terminated. If this is a re-credentialing application, and the provider fails to respond to a request for corrective information, network privileges will be terminated and notification will be mailed to the provider, together with the Provider's Rights and Appeal Handout.
10. Fair and impartial review by the Committee based on the presentation of the documents required for application and credentialing and re-credentialing primary source verification;
11. Privacy such that provider information is treated confidentially. Provider information and files are kept in a locked, secure file with only authorized personnel able to access such information. Authorized persons are: the Executive Director, the Director of Administrative Operations, the Senior Care Manager, the Provider Relations Specialist and the Medical Director. The Credentialing Committee shall review files when directly related to the credentialing or peer review activity. (This information shall be kept according to Federal Standards

regarding confidential information.) Each Provider will be assigned a provider number, this Provider Number will consist of the first initial of the provider's first and last name together with the last four digits of the Provider's tax id number. This number or code will be used in documenting dialogue or discussion by the Credentialing Committee in the meeting minutes.

12. Timely notification of re-credentialing. The provider will have notification and material for re-credentialing six months in advance of expiration of the credentialing status. Approved credentialing status will expire three years from the date of the initial credentialing decision,

Provider Rights With Regard to Peer Review:

The Credentialing Committee oversees the performance of the providers within New Avenues Networks. As part of that responsibility, there may be the need to address complaints, grievances, or performance issues related to a provider. These may include but not be limited to situations of:

1. Quality assurance studies that indicate performance of the provider is not consistent with the practice of the majority of like providers, as may be indicated by significant over or under-utilization;
2. Complaints about the provider that are submitted from staff, members, member representatives, other providers, primary care doctors, or others related to the New Avenues delivery system;
3. Grievances that are submitted by members, providers, or someone representing an enrollee or member;
4. Member satisfaction surveys that indicate dissatisfaction with a provider for repeated minor events, or a single significant events,
5. Staff or member report of provider failure to consistently provide necessary documentation for utilization review, for failure to abide by New Avenues policies, or inappropriate billing practices that are not compliant with health plan requirements;
6. Report of events that are infractions of the professional's code of conduct, unprofessional behavior; or unethical behavior;
7. Evidence of the provider not meeting the conditions of the contract or credentialing criteria during the three year interim period;
8. Events that are revealed through utilization review activities that indicate the practice of behavioral care was outside of professional practice standards, potentially dangerous to a patient, negligent, or of questionable effectiveness for a patient's care; or
9. Or other actions by a provider that negatively reflect upon New Avenues, enrollee confidence in its operation, or its reputation for protecting the interests of the member.

Any such incidents will require that New Avenues investigate the provider for not fulfilling his/her responsibilities to the health plan and members. Under such conditions, New Avenues shall follow the following procedures.

Under situations of quality assurance analysis, such as utilization data analysis, in the event that a provider demonstrates under or over-utilization, this practice pattern shall be addressed within the Credentialing Committee. If it is the opinion of the Committee that

practice issues should be brought to the attention of the provider in order to bring about improvement or change, the Executive Director or Medical Director shall bring the issue to the attention of the provider with a spirit of asking for cooperation. The provider shall be given the right to respond in writing to the Medical Director or Executive Director with explanation or additional information. Monitoring of the Provider's practice patterns may be also instituted.

When situations emerge related specifically to the provider's treatment or office practice, such as a member's complaint/grievance, or a staff person's concerns with utilization review/performance issues, or complaints submitted by a member on a Client Satisfaction Survey, New Avenues will follow-up and open an investigation into the complaint, utilizing the policy and procedures outlined in UM 204:4.

1. In the event that the situation cannot be resolved through negotiation, or provider education, then the situation shall be brought to the Credentialing Committee for additional action. Otherwise the situation shall be brought to the Committee for information purposes only. Documentation of the proceedings shall be a part of the Credentialing Committee, and findings placed in the provider's file.
2. In the event that corrective action is required, the Provider Relations Coordinator, or the Executive Director shall articulate in a letter, with approval by the Medical Director and with direction of the Committee, an outline of appropriate actions to rectify the situation. Such interventions shall also stipulate a timeframe.
3. New Avenues shall do follow-up to ensure the situation is rectified, that recommendations for future training are undertaken, or that performance is improved. Failure to rectify a situation shall be brought back to the Credentialing Committee for action.

Serious Infractions of Conduct, Negligence or Actions Resulting in Adverse Incidents:

In situations for which there are allegations of serious infractions of professional conduct, signal events that suggest negligence, or failure to perform one's professional duties that resulted in an adverse event for a patient, harm, or injury to a patient, or significant loss of confidence or harm to the reputation of New Avenues, then New Avenues shall conduct its investigations and follow the following procedure.

1. The investigations must be triggered by reasonable information that is based upon allegation from a member, member representative, another provider or healthcare professional that there has been serious infraction by the provider, and that the member is grieving a provider's behavior;
2. The Complaint shall be logged into the Complaint/ Grievance log by the Senior Care Manager or Executive Director, and a complaint form filled out.
3. The receipt of the complaint shall be acknowledged to the member within 3 days, and the Payor if required.
4. In the event that the member has not submitted a written letter describing the complaint, such written description of complaint shall be requested of the member by the Senior Care Manager or the Executive Director through a written request to the member using the Complaint Grievance Form. New Avenues also shall ask the member for consent to communicate with the relevant parties in order to conduct the investigation. This will have a timeframe for response of ten days. New Avenues

- may involve consultation with the Medical Director, insurance carrier, or legal counsel prior to the request for such written description and during the investigation.
5. In the event that the member, or member representative fails to respond, the allegation shall be discussed within the Credentialing Committee. At this point, several options may be considered including request of the medical record;
 6. In the event that the member does provide a written complaint, then New Avenues shall notify the provider of the allegation within 5 days of receipt of the written complaint, shall perform an investigation by requesting the record, and asking the provider for written statement with explanation of events, to be sent within a 10 day period to New Avenues. Failure to respond may represent a condition of suspension of panel approved status.
 7. Upon obtaining the information, the situation should be reviewed by the Medical Director within 15 days, and the Credentialing Committee within 60 days. At the time of Credentialing Committee review, interventions and sanctions may be applied to the provider.
 8. New Avenues reserves the right to consider a range of interventions and sanctions that are appropriate to the situation including a recommendation to the provider to make some change, a reprimand, a recommendation or requirement for training or continuing education, monitoring performance, suspension of privileges to participate, restriction of participation, or expulsion from the Network.
 9. The Provider shall be notified in writing of the Committee's findings within five days of the Committee's decision and applied interventions; such letter shall give the Provider reasons for the finding and if determined, appropriate timelines for corrective action or monitoring of performance, and notification of the right to an appeal hearing.
 10. The Provider may appeal the Committee action by sending written request for an appeal within 10 days, explanation of reasons, and provide additional information that may bear on the decision.
 11. An appeal request should be submitted to the Provider Relations Department at the New Avenues business address.
 12. On serious quality infractions, such as professional misconduct, competence, unethical behavior, loss of license, negligence, or illegal actions where there is a concern for member or public safety, where decisions of the Credentialing Committee and any sanctioning that involves termination of panel status, Provider Relations Coordinator will report within five (5) business days its actions to the appropriate state licensing board, and the National Providers Data Bank.
 13. The Provider has a right to review copies of information submitted regarding any allegations about the Provider except for confidential discussion held by the Credentialing Committee conducting peer review. All expenses for faxing and copying of materials are the responsibility of the provider.
 14. The Provider has a right to a fair hearing with the Credentialing Committee within 60 days; the provider shall have 20-day notification of such meeting, a right to provide additional information that pertains to the case, and a right to representation at a hearing. A written decision of the outcome of the hearing shall be prepared within five working days of the hearing and shall be sent to the provider. The outcome of the hearing shall provide a statement for the basis of the decision. Such action shall be considered final.