G.E.H.A | Connection Dental Network

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GEHA/Connection Dental Network
Credentialing, Recredentialing
And Quality Assurance Program
Policies and Procedures

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PURPOSE

The Policies and Procedures described in this document present a fair and reasonable process to evaluate Credentialing Applications for acceptance into, and for continuing participation in, Connection Dental Network (the "Network"), a non-risk bearing PPO network owned and operated by Government Employees Health Association, Inc. ("GEHA"). The Network conducts credentialing, recredentialing and quality assurance activities for providers under contract with GEHA and on behalf of PPOs and other payors who provide dental care services to their members or enrollees. The following criteria and standards are modeled on those set forth by URAC and NCQA.
These Policies and Procedure will be reviewed and approved by the Peer Review Committee and the Dental Director annually.

POLICY

The Network documents the mechanism for the credentialing and recredentialing of all Providers and presents them for approval before the Peer Review Committee before execution of a Provider Agreement by the Network or approving Participating Providers for continued participation in the Network. The Network performs the ongoing monitoring of provider credentials and its review of continued compliance with GEHA policies, procedures, provider contracts, URAC and NCQA Standards and applicable state laws through its Quality Assurance Program.

PROCEDURES

I. Scope

The Network complies with URAC and NCQA standards for all credentialing, recredentialing, and quality assurance functions. Under this program, the Network will credential and recredential all Providers who are providing dental care services and who the Network lists or intends to list in the Network's provider directory or website. The Network will obtain meaningful advice and expertise from its Peer Review Committee when making credentialing decisions. The Network will monitor Participating Providers' credentials and quality of care and services on an ongoing basis to ensure Participating Providers continuously meet or exceed GEHA policies and procedures, provider contract, URAC and NCQA standards, and applicable state law requirements. The Network may delegate credentialing and recredentialing activities for contracted providers as necessary to entities that meet or exceed GEHA requirements, URAC, and NCQA Standards, and applicable state laws. This delegation may include, but is not limited to, DDS and DMD providers. GEHA retains the final authority to approve new Providers and to terminate or suspend individual Providers in the Connection Dental Network.

The Network's Credentialing Program decisions are made in a non-discriminatory manner. Credentialing decisions are based on multiple criteria related to professional competency, quality of care, and appropriateness by which health or dental services are provided. No Non-Participating Provider shall be denied membership in the Connection Dental Network based on race, ethnic/ national

identity, color, creed, ancestry, gender, gender identity, sexual orientation, age, religion, marital status, ethnic/national origin, physical, mental, or sensory disability, health status unrelated to the ability to fulfill patient care, or on type of procedure or patient (e.g., Medicaid) in which the Provider specializes. Audits of non-discrimination will be conducted on an annual basis by the Senior Credentialing Representative. Such audits will entail the review of monthly reports relative to initial credentialing decisions and provider terminations. Upon review of the reports, if it appears that any credentialing decision was discriminatory, the Dental Network Manager, Credentialing Supervisor, and Senior Credentialing Representative will evaluate the file in full. The Legal Department will be apprised if discrimination was a factor in any credentialing decision.

Definitions

A. Ad-Hoc Provider: Specialty expertise to be a standing committee member to participate as a clinical peer on a Dispute Resolution Committee or Appeal Reconsideration Committee panel.

B. Appeal Reconsideration Committee: The Appeal Reconsideration Committee is comprised of a group of individuals that impartially reviews appeals of adverse decisions of the Dispute Resolution Committee in accordance with the procedures set forth in Article XIX below, except that for Washington providers, the procedures are set forth in Article XX below. The committee shall consist of at least three qualified individuals, of which at least two may be Peer Review Committee members not involved in the initial adverse action(s) or adverse Dispute Resolution Committee decision, and one who is a Participating Provider who 1) is not a member of the Peer Review Committee; 2) has no other role in management of the Network; and 3) is a clinical peer of the Participating Provider who filed the dispute. This committee may not consist of any individual who was involved with the Dispute Resolution Committee's decision. The Appeal Reconsideration Committee manages all appeal reconsiderations and makes the final decisions regarding adverse actions related to a Participating Provider's status within the Network and a Participating Provider's professional competency or conduct. This panel is called the Second Level Appeal Panel for Participating Providers in the State of Washington.

C. Clean Application: A Clean Application is one that does not require Peer Review Committee review because (1) there are no issues that would require review by the Peer Review Committee, (2) the File meets the minimum URAC and NCQA credentialing standards identified in the Credentialing Process or Recredentialing Process, and (3) the File meets any additional criteria determined by the Network.

D. Completed Credentialing Application: An application that contains all credentials data.

E. Conflict of Interest: A conflict of interest may exist for a committee member whenever the outcome of a committee's deliberations could result in personal economic, or other advantage or disadvantage to a committee member personally, or to a committee member's immediate family, or to the Provider or group with which a committee member practices.

F. The Connection Dental Department of the Network or Connection Dental Department: The department of the Network that executes and maintains Provider Agreements and manages various Provider issues.

G. Credentialing Application or Recredentialing Application: Forms that request general information from a Dental Health Professional applying for initial credentialing or recredentialing with Network. A Completed Credentialing Application or Recredentialing Application will contain the following:

1. A signed and dated application with authorization and release of liability statement.

2. Verification from application view of any of the following that apply to Provider:

(a) Date of Birth
(b) Current hospital affiliations, if applicable
(c) Five-year work history
(d) Any conviction of or plea of guilty or nolo contendere to a felony or misdemeanor under state or federal law except for North Carolina where only convictions of a felony or misdemeanor under state or federal law will be considered.

3. Verification from primary/or secondary sources of any of the following that apply to Provider:

(a) current, valid State license(s) to practice dentistry or to practice within scope of education, depending on where the Provider intends to provide care, and history of State licensure in all jurisdictions,
(b) current, valid Controlled Substance licenses, if applicable
(c) current, valid Sedation/Anesthesia license(s), if applicable
(d) current, valid Drug Enforcement Agency (DEA) certificate, if applicable
(e) dental school with year graduated, latest training completed, or American Board certification, if applicable
(f) current Medicaid/Medicare status
(g) current professional liability insurance as required by GEHA and applicable state law
(h) professional liability claims history during prior five years

NOTE: Both DEA certificates and Controlled Substance certifications and Sedation/Anesthesia licenses will be reviewed for Rhode Island applications.

4. A statement from the Provider should be included if a provider responds affirmatively to any of the following professional and health status questions that apply to Provider:
    - (a) malpractice actions taken against Provider during previous five years, if the Provider has been in practice that long
    - (b) suspension or limitation of hospital privileges or surrender of hospital privileges while under investigation
    - (c) suspension or sanction as a Medicare, Medicaid or other Federal or State government program provider during previous five years, if the Provider has been in practice that long
    - (d) professional liability insurance denied, canceled, or not renewed, including any denial, cancellation or nonrenewal of policies during previous five years
    - (e) any State licensing investigation or action, including any denied, revoked, expired, suspended, or restricted license
    - (g) any DEA or State Drug Certificate licensing investigation or action or sanction activity
    - (h) Any conviction of or plea of guilty or nolo contendere to a felony or misdemeanor under state or federal law except for North Carolina where only convictions of a felony or misdemeanor under state or federal law will be considered
    - (i) chronic illness, physical defects or substance abuse that would impair the ability to practice
    - (j) current use of illegal drugs
    - (k) any gaps of six months or greater of employment during the previous five years
5. NPDB query report obtained by Network Representative
6. Network's Quality Assurance Program results, if applicable

H. Credentialing Criteria: Defined criteria set forth in the Connection Dental Initial Credentialing Criteria for Non-Participating Providers and the Connection Dental Recredentialing Criteria for Participating Providers that are reviewed during the Credentialing Process or Recredentialing Process by the Network Representative.

I. Credentialing Department: The credentialing department of GEHA.

J. Credentialing Process: Process by which Credentialing Criteria for Non-Participating Providers are verified for use in determining the initial approval for Network participation.

K. Credentialing Program: The program described in these Policies and Procedures, including the Credentialing Process, Recredentialing Process and Quality Assurance Program.

L. Credentialing Supervisor: An individual appointed by GEHA as the Credentialing Supervisor who may have a Certified Provider Credentialing Specialist Certification, or his/her designee. The Credentialing Supervisor has the authority to submit any Participating Provider's adverse or potentially adverse credentialing information to the Peer Review Committee for review at any time.

M. Credentials Verification Organization Vendor or CVO Vendor: A company that is fully accredited by URAC/NCQA as a Credentials Verification Organization and that facilitates the transmittal of credentials data from the primary source of the credentialing information to GEHA.

N. Delegated Credentialing: A transfer of authority and responsibility that occurs when the Network contracts with a party to perform Credentialing functions as outlined in the group or facility agreement. (The party can be a CVO.) The Delegated Credentialing functions must meet or exceed GEHA Credentialing Criteria, Policies and Procedures, URAC and NCQA standards and applicable state laws. Any credentialing functions not specifically delegated to another party remain the responsibility of GEHA.

O. Dental Director: A Doctor of Dental Medicine or Doctor of Dental Surgery degree who is duly licensed to practice dentistry, and who is an employee of, or party to a contract with, GEHA; and who has responsibility for the overall oversight of the Network's Credentialing Program. The Dental Director has been delegated authority, by the Peer Review Committee, for approving Clean Applications and a delegated entity's policies and procedures and may further delegate such authority to the Dental Director. The Dental Director may be responsible for reviewing Quality Assurance Program Occurrences regarding any Provider who is engaged in behavior or is or may be practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of consumers, and has the authority to terminate Participating Providers from the network for any of the reasons set forth in Article XVII below.

P. Dental Health Professional: An individual who: (1) has undergone formal training in a dental care field; (2) holds an Associate or higher degree in a dental care field or holds a state license or state certificate in a dental care field; and (3) has professional experience in providing direct patient care. The foregoing shall include, but not be limited to, DDS and DMD. If permitted by state law, a Dental Health Professional may be an individual who (1) has undergone formal training in a healthcare field; (2) holds a state license or state certificate in a healthcare field; and (3) has professional experience in providing direct patient care. The foregoing shall include, but not be limited to, an MD.

Q. Dispute Resolution Committee: The Dispute Resolution Committee has the responsibilities set forth in Article XIX.B and Article XX.A.2. The committee is comprised of a group of individuals that impartially reviews any dispute concerning Peer Review Committee or Dental Director's

decisions that relate to a Participating Provider's status within the Network and that may relate to a Participating Provider's professional competency or conduct. This committee shall consist of three qualified individuals, of which two may be Peer Review Committee members not involved in the adverse action being appealed and one shall be a Participating Provider who (1) is not a member of the Peer Review Committee; (2) has no other role in management of the Network; and (3) is a clinical peer of the Participating Provider who has requested a dispute resolution appeal in accordance with the procedures set forth in Articles XIX and XX. This panel is called the First Level Dispute Panel for Participating Providers in Washington.

R. File: The compilation of information about a Provider that includes all credentialing information, the Provider Agreement, and all Quality Assurance Program Occurrences.

S. Network: Connection Dental Network, a non-risk bearing network owned and operated by GEHA.

T. Network Representative: Dental Director or any member of the Peer Review Committee; Chairperson or his/her designee; a Co-Chair or his/her designee; the Manager, Provider Network or his/her designee; the Credentialing Supervisor or his/her designee; the Senior Credentialing Representative, Quality his/her designee; any employee or staff member of the Network; a board member of GEHA; a CVO Vendor; and any individual appointed by or authorized by any of the foregoing to perform specific functions related to gathering, analysis, use or dissemination of information.

U. Non-Participating Provider: A Dental Health Professional who has not been credentialed by the Network or entered into a Provider Agreement with the Network to provide dental care services.

V. Participating Provider: A Dental Health Professional who has been credentialed by the Network and has entered into a Provider Agreement with the Network to provide dental care services.

W. Peer Review Committee: The Peer Review Committee is a group that meets as often as necessary, but no less than monthly and may meet telephonically so long as all parties can hear each other, and: (1) includes at least one non-employed dental practitioner that reflects the type of practitioners in the network; (2) discusses whether providers are meeting reasonable standards of care; (3) accesses appropriate clinical peer input when discussing standards of care for a particular type of provider; (4) has final authority to approve or disapprove Credentialing Applications and Recredentialing Applications by Providers; has final authority to approve or disapprove the participation status of Participating Providers who have Quality Assurance Program Occurrences; and has final authority to approve or disapprove the participation status of groups with delegated credentialing. The Peer Review Committee may delegate such authority

to the Peer Review Committee Chairperson and Co-Chair (Dental Director) for approving Clean Applications, approving continued participation status of Participating Providers who have Quality Assurance Program Occurrences, and approving Delegated Credentialing groups' policies and procedures and triennial audits; (5) maintains minutes of all Peer Review Committee meetings and documents all actions; (6) provides guidance to Network staff on the overall direction of the Credentialing Program; (7) evaluates and reports to Network management annually on the effectiveness of the Credentialing Program; and (8) reviews and approves Policies and Procedures. The Peer Review Committee must consist of at least three Dental Health Professionals, one of whom should be the Committee Chairperson, the Co-Chair, or their designee, and such others as authorized herein. Additional responsibilities include providing suggestions and/or guidance to the Network regarding clinical and provider payment policies, member access to care, dispute resolution policies, and other Network management processes and policies. In addition, the Peer Review Committee may be asked to review Quality Assurance Program Occurrences as part of its ongoing quality oversight mechanism. Each member of the Peer Review Committee is required to be a Doctor of Dental Medicine, a Doctor of Dental Surgery, or another specialty that is represented in the Network. The member must be duly licensed to practice in at least one state in the United States, an employee of or a party to a contract with Network and have post-graduate experience in direct patient care. The Peer Review Committee shall include at least one of the most common types of providers in the Network and consist of a diverse range of dental specialties and membership.

X. Peer Review Committee Chairperson and Co-Chair ("Chairperson" and "Co-Chair," respectively): The Chairperson and Co-Chair have the responsibility for the Credentialing Process and Recredentialing Processes at the Peer Review Committee meetings. The Co-Chair serves as the Network's Dental Director and clinical decision-maker for the Quality Assurance Program. The Dental Director is responsible for reviewing clinical Quality Assurance Program Occurrences and working with Network Representatives to request clarification or additional information from Participating Providers, when needed. The Dental Director is also responsible for presenting Quality Assurance Program Occurrences to the Peer Review Committee when appropriate. Each Chairperson must be a doctor of dentistry who is duly licensed to practice in at least one state in the United States, who is an employee of or a party to a contract with Network and has post-graduate experience in direct patient care. Either the Chairperson or the Co-Chair must be a Participating Provider who has no other role in the organization's management.

Y. Policies and Procedures: Policies and Procedures are those policies and procedures as set forth herein as may be amended from time to time.

Primary Source Verification: Verification by the Network or a CVO Vendor of a Dental Health Professional's qualifications and credentials based upon evidence obtained by direct contact with the issuing source. Primary Source Verification may include state licensing Boards, Sedation/Anesthesia license(s), from the applicable source, otherwise a copy of license or an attestation, school/residency/training programs, Board certification via ADA master file, a Dental Board, the Education Commission for Foreign Graduates, or a National Clearing House. Primary source verification of DEA is by the U.S. Department of Justice DEA Diversion Control Division.

Z. Provider: Any Participating or Non-Participating Provider.

AA. Provider Agreement: A contract between the Network and a Dental Health Professional whereby the Dental Health Professional agrees to provide dental care services consistent with standards of good practice in the United States and abide by the Network's policies and procedures. A completed Provider Agreement will contain the following:

1. Original signature of the Provider indicating agreement of terms and conditions.

2. Attached fee schedule and/or rate with no revisions noted.

BB. Quality Assurance Program: A process of review to assess ongoing monitoring, member complaints, and actual or potential adverse credentialing, adverse administrative, adverse quality of care or service issues, and/or adverse non-clinical matters for Participating Providers.

CC. Quality Assurance Program Occurrence: A finding that a consumer safety issue exists with respect to a Participating Provider resulting from actual or potential adverse quality of care or services provided to consumers; a finding that an actual or potential adverse credentialing issue exists; a finding that an actual or potential adverse administrative or non-clinical matter exists; a complaint about a Participating Provider who may be engaged in behavior or practicing in a manner that appears to not be of a quality consistent with generally accepted standards and practices in the dental community; or an actual or potential finding that a Participating Provider no longer meets the Credentialing Criteria.

DD. Recredentialing Process: A process of review to assess and update the qualifications and credentials of a Dental Health Professional for ongoing Network participation as set forth in Article VI below.

EE. Secondary Source Verification: Verification by the Network of a Dental Health Professional's qualifications and credentials based upon evidence obtained by legitimate means other than direct contact with the issuing source or the credential (e.g., copies of required documentation).

FF. Summary Suspension: Network causes Participating Provider's locations to be removed from all directories by deselecting the option to list the locations in the directories.

GG. Termination: The termination of a Participating Provider's network participation and Provider Agreement pursuant to these Policies and Procedures or the Provider Agreement.

HH. Washington Network Participation Disputes: A Network participation dispute process that is required to be available to Participating Providers in the State of Washington and that is subject to Washington laws and regulations.

III. Credentialing Application Process

The provisions of this Article III shall govern the application process for Dental Health Professional(s).

A. Submitted Application must include the following minimum credentialing requirements:

1. Date of Birth
2. History of dental school education and year graduated dental school, professional training and year graduated professional training, and Board certification information, if applicable
3. Current state licensure information including history of state licensure in all states
4. Current Sedation/Anesthesia license(s), if applicable
5. History of any state licensure investigations or actions, within the last five years unless otherwise required by applicable state law (this dictates Peer Review)
6. Status of Medicare, Medicaid, or other government program provider
7. Current Drug Enforcement Agency (DEA) licensure information, if applicable
8. History of any DEA licensure investigations or actions within the last five years unless otherwise required by applicable state law (this dictates Peer Review).
9. Proof of current professional liability insurance, or exemption noted if Provider resides in a United States Territory, including American Samoa, Guam, Northern Marianas, Puerto Rico, and the Virgin Islands. (If a Provider resides in a U.S. Territory and does not maintain professional liability insurance, this dictates Peer Review.)
10. History of professional liability insurance being denied, canceled, or not renewed for unprofessional conduct within the last five years (this dictates Peer Review).

11. History of any malpractice issues in previous five. Any provider with malpractice issues involving two or more cases closed with payment and/or any one case with a settlement greater than $30,000 (this dictates Peer Review). Current hospital affiliations, if applicable
12. History of any suspension or limitation of hospital privileges or surrender of hospital privileges while under investigation (this dictates Peer Review); For Nebraska Providers, hospital privileges will be primary source verified.
13. Disclosure of any physical, mental, substance abuse problems that could, without reasonable accommodation, impede the Provider's ability to provide care according to accepted standards of professional performance or pose a threat to the health or safety of patients (this dictates Peer Review).
14. Disclosure of immediately preceding five-year work history
15. Disclosure of felony(ies) and/or misdemeanor(s) under federal or state law (this dictates Peer Review).
16. A signed and dated statement attesting that the information submitted with the application is complete and accurate to the Provider's knowledge and that includes a release of liability statement.

B. If the applicant does not submit at least the minimum information outlined above, a Network Representative or the CVO Vendor shall inform the applicant of the Network's requirements, and the Provider will not be included in the Credentialing Process.

C. In instances where a state requires utilization of an application which contains content unique to state requirements, the provider is required to complete the state-mandated application. North Carolina is one of these states and includes the following required information, when applicable:

The provider's name, address, and telephone number.

Practice information, including call coverage.

Education, training, and work history.

The current provider license, registration, or certification, and the names of other states where the applicant is or has been licensed, registered, or certified.

Drug Enforcement Agency (DEA) registration number and prescribing restrictions.

Specialty board or other certification.

Professional and hospital affiliation.

The amount of professional liability coverage and any malpractice history.

Any disciplinary actions by medical organizations and regulatory agencies.

Any felony or misdemeanor convictions.

The type of affiliation requested, for example, primary care, consulting specialists, ambulatory care.

A signed and dated statement by the provider attesting that the information provided is true, accurate, and complete, and authorizing the release of information and materials related to the provider's qualifications and competence.

Letters of reference or recommendation or letters of oversight from supervisors, or both, that attest to the qualifications or competence of the provider or otherwise recommend approval of the provider's application.

D. Documentation, including but not limited to provider applications, notices, and QAP matters relating to the credentialing/recredentialing of a provider shall be maintained by the network electronically.

IV. Initial Credentialing Process for Non-Participating Providers

The provisions of this Article IV shall govern the Credentialing Process for Non-Participating Providers.

A. Credentialing Application File

1. By signing, dating, and submitting a Credentialing Application, the Non-Participating Provider:

(a) Disclosure of felony or misdemeanor; Acknowledges and attests that the Credentialing Application is correct and complete and acknowledges that any significant misstatement or omission is grounds for a denial of membership or for termination from the Network.

(b) Consents to the release and review by Network Representatives of all documents for the purpose of credentialing and recredentialing (including requesting and reviewing information from the National Practitioner Data Bank ("NPDB") and any other data bank the Network is permitted or required by law to access) that may be necessary to evaluate his or her professional qualifications and ability to meet the qualifications to participate in the Network, initially and on an ongoing basis, as well as his or her professional ethical qualifications for Network membership, and consents to Network Representatives

consulting with prior associates or others who may have information bearing on his or her professional or ethical qualifications and competence.

(c) Understands and agrees that if membership is denied based on the Non-Participating Provider's professional competence or conduct, the Non-Participating Provider may be subject to reporting to the NPDB.

(d) Releases from any liability all Network Representatives and/or the GEHA Board of Directors for their acts performed in good faith and without malice in connection with reviewing, evaluating, or acting on the Credentialing Application and the Non-Participating Provider's credentials.

(e) Releases from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to Network Representatives and/or the GEHA Board of Directors in good faith and without malice concerning the Non-Participating Provider's ability, professional ethics, character, physical and mental health, emotional stability, and other qualifications necessary for appointment as discussed herein.

(f) Agrees that any lawsuit brought by Non-Participating Provider against an individual or organization providing information to a Network Representative and/or the GEHA Board of Directors or against the Network or Network Representatives or the GEHA Board of Directors, shall be brought in a court, federal or state, in the state in which the defendant resides or is located.

(g) Agrees to practice in an ethical manner and to provide continuous care to patients.

(h) Agrees to notify the Network immediately if any information contained in the Credentialing Application changes. The foregoing obligation shall be a continuing obligation of the Non-Participating Provider so long as he or she is a member of the Network.

(i) Agrees to be bound by the terms of and to comply with all respects of these Policies and Procedures.

2. Once the signed and dated Credentialing Application with release of liability and the supporting documents are received from the Non-Participating Provider the following information will be verified:

(a) History of education and professional training, including Board certification status, if applicable; Primary Source Verification must include a state licensing board, school/residency/training program, Board certification via

master file, ADA master file, the Education Commission for Foreign Graduates, or a National Clearing House. The Network will make at least three attempts to verify foreign education.

(b) State licensure information, including any current license in states where the practitioner is providing care to members; Primary Source Verifications via state licensing Board must include the expiration date of the license, the date it was verified, and whether there are any sanctions on the license. The license must be current and valid when presenting to the Peer Review Committee. For providers in North Carolina, state licensure information will also be gathered for all licenses in states other than where the practitioner is providing care to members. Primary Source Verification via state licensing Board or Secondary Source Verification via current copy that is valid at the time of the credentialing decision.

(c) Drug Enforcement Agency (DEA) certification information, if applicable; Primary Source Verification via U.S. Department of Justice Drug Enforcement Administration Diversion Control Division or Secondary Source Verification via current copy that is valid at the time of the credentialing decision.

(d) Sedation/Anesthesia licensure information, if applicable

I Proof of liability insurance, Secondary Source Verification of the liability insurance cover sheet. The cover sheet must include the name of the Non-Participating Provider, the expiration date and the liability covered. If the cover sheet does not include the name of the Non-Participating Provider, then a photocopy of those covered under the plan must be submitted on a sheet that includes the insurer's letterhead. The cover sheet must be current and valid when presented to the Peer Review Committee. Self-insured, Federal Tort (FTCA) and State Tort Insurance policies are acceptable and may not include Provider's name.

(f) History of professional liability insurance status, which is verified by the NPDB query; Credentialing Application requires disclosure of denied, canceled, or not renewed professional liability insurance.

(g) Professional liability malpractice claims history, which is verified by the NPDB query; Credentialing Application requires disclosure of malpractice claims history for all cases that are settled or have resulted in an adverse judgment against the Non-Participating Provider.

(h) History of sanctions; Credentialing Application requires disclosure of sanction history from state including Sedation/Anesthesia, if applicable, and DEA licensing Boards as well as government programs. The Office of Inspector General (OIG)'s Exclusion List, the Office of Foreign Assets Control's (OFAC's) Listing and the Excluded Parties List System (EPLS) are used to verify government sanctions.

(i) History of suspension or limitation of hospital privileges or history of surrender of hospital privileges while under investigation, which is verified by the NPDB query; Credentialing Application requires disclosure of suspension or limitation of hospital privileges, if applicable.

(j) Current hospital affiliations, if applicable; Credentialing Application requires current affiliation information, if applicable.

(k) Disclosure of any physical, mental, or substance abuse problems that could, without reasonable accommodation, impede the Non-Participating Provider's ability to provide care according to accepted standards of professional performance or pose a threat to the health and safety of patients; Credentialing Application requires disclosure of any threat to the health or safety of patients.

(l) Disclosure of Non-Participating Provider's immediately preceding 5-year work history; Credentialing Application requires 5 years' work history if the Non-Participating Provider has been in practice that long.

(m) Credentialing Application requires disclosure of any conviction of or plea of guilty or nolo contendere to a felony or misdemeanor under state or federal law except for North Carolina where the Credentialing Application requires disclosure of felony or misdemeanor convictions.

(n) A signed and dated attestation that the information submitted with the Credentialing Application is complete and accurate to the Non-Participating Provider's knowledge and that includes a release of liability statement. An electronic signature is acceptable to meet this requirement.

V. Decision on Network Participation for Initial Applications

A. Basic Requirements

1. The Non-Participating Provider is responsible for providing a Completed Credentialing Application and for producing information adequate to properly evaluate his or her ability to meet the qualifications to participate in the Network, including, but not limited to, experience, background, training, demonstrated competence, utilization patterns, work habits, and other history, to resolve any doubts or conflict, and to clarify information as requested by Network Representatives, including but not limited to the Credentialing Supervisor, Chairperson, a Co-Chair, or a Peer Review Committee Member.

2. The Non-Participating Providers' Files that include incomplete Credentialing Applications or insufficient information to meet the minimum credentialing requirements are not submitted to the Peer Review Committee. A letter will be sent to the Non-Participating Provider as expeditiously as possible, but in no event later than 90 days following the date of receipt of the Application**,** informing him or her that the Application is incomplete, unless a shorter timeframe is required by law. The Credentialing Process will be placed in verification pending status until such time that the minimum credentialing requirements are provided to the Credentialing Department, or the credentialing timeframe is exhausted.

B. When a Non-Participating Provider applies to join the network within the one-year waiting period following a final adverse action or termination for contract default, a letter will be mailed to the Non-Participating Provider as expeditiously as possible, but no later than 90 days following the date of receipt of the Application, informing him or her that the Application is ineligible for consideration during the one-year waiting period.

Procedures for Processing Initial Applications

1. Prior to each Peer Review Committee, the Chairperson or Co-Chair will remind committee members to consider Conflict of Interest issues. If a Conflict of Interest exists for any committee member, the member shall not participate in deliberation and/or voting on any matter related to the File. If there are any questions concerning whether a Conflict of Interest exists, members should address questions to the Chairperson before any activity on the File. Whenever a conflict exists, the minutes of the relevant meeting will reflect the disclosure of the fact of a member's conflict and that the member did not participate in deliberation or voting on the matter.

2. The meetings of the Peer Review Committee and the Files will be considered confidential. The Chairperson or Co-Chair will remind the Peer Review Committee prior to each committee meeting of the necessity of confidentiality. The File shall not be subject to discovery, subpoena, or other means of legal compulsion of their release.

3. The Peer Review Committee will review the Credentialing Application and accept, deny, or defer the Non-Participating Provider's acceptance into the

Network within 90 days of receipt of the Completed Credentialing Application, unless a shorter timeframe is required by law, in which case the Network will comply with applicable law.

4. The Peer Review Committee may defer a Credentialing Application to request clarification(s) and/or additional information from the Non-Participating Provider related to the Credentialing Process; to request input from a clinical peer of the Non-Participating Provider; or to request additional information about the Non-Participating Provider from a Network Representative. The Peer Review Committee will consider appropriate clinical peer input when discussing standards of care for a particular provider type. A Non-Participating Provider shall have 30 days to submit clarification(s) or additional information after such request is sent to the Non-Participating Provider. Such requested information shall be delivered to the Senior Credentialing Representative, Quality or his/her designee and shall be forwarded to the Peer Review Committee. If the requested information is not provided within the time and manner specified in the request, the Peer Review Committee may review the Credentialing Application based on the available information or find it to be incomplete and continue to defer the File until the information is received or the credentialing timeframe is exhausted.

5. A Non-Participating Provider may withdraw his or her initial Application at any time during the initial Credentialing Process. The withdrawal of an initial Application *after* a final denial action will result in the final denial action being reported to the NPDB.

C. Grounds for Denial of Initial Application

1. Criteria for Denial of a Credentialing Application: The Peer Review Committee may deny a Credentialing Application for any reason set forth in these Policies and Procedures and the Connection Dental Initial Credentialing Criteria, as amended from time to time, and such reasons include, but are not limited to, the following:

(a) The Non-Participating Provider education is unsatisfactory.

(b) The Network has previously terminated the Non-Participating Provider or denied a Non-Participating Provider for Credentialing or Recredentialing participation in the Network in the previous year.

(c) The Non-Participating Provider's credentials are unsatisfactory.

(d) The Non-Participating Provider previously was convicted of, or plead guilty or nolo contendere to, or entered into a settlement with a state or federal agency during a criminal prosecution under the laws of any state or of the United States for any felony or any offense reasonably related to the qualifications, functions or duties of the medical or

dental profession, or for any offense an essential element of which is fraud, dishonesty or an act of violence or an act involving moral turpitude. For North Carolina Non-Participating Providers only, a guilty or nolo contendere plea will not be a reason for denial of an initial application.

2. Criteria for Automatic Denial: A Credentialing Application may be automatically denied during the Credentialing Process for any of the reasons set forth in Article XVII.B. This action shall be final except when a bona fide dispute exists as to whether the circumstances have occurred. No Non-Participating Provider shall be entitled to the procedural rights set forth in Articles XVIII, XIX or XX as the result of an automatic denial imposed pursuant to this section. If the Credentialing Application is automatically denied, a Network Representative shall send a signature confirmation letter of the decision to the Non-Participating Provider and a copy of the letter will be placed in the File.

D. Decision on Network Participation

1. The Chairperson, Co-Chair and the Peer Review Committee will review the credentialing information and make decisions at a committee meeting and determine if the Non-Participating Provider will be accepted into the Network.

(a) Approval. If the Peer Review Committee approves a Non-Participating Provider Credentialing Application, the Credentialing Department will send notification to the Non-Participating Provider of the determination of his/her Credentialing Application and the specialty under which the Non-Participating Provider will be listed in directories within 10 business days of the determination. The Connection Dental Department shall send notification of the Non-Participating Provider's participation effective date. A copy of the original executed contract and the notice of participation effective date will be placed in the File.

(b) Deferral. If the Credentialing Process for a Non-Participating Provider Credentialing Application is deferred by the Peer Review Committee to request clinical peer input or additional information from the Network, such information and the Credentialing Application will be reviewed at a Peer Review Committee meeting. If the Credentialing Process is deferred by the Peer Review Committee to request additional information or clarification(s) from a Non-Participating Provider, the Senior Credentialing Representative, Quality or his/her designee shall continue to follow up in good faith to request additional information or clarification(s) from the Non-Participating Provider, by

means of telephone, email, postcard, fax or by written request until the information is received or the credentialing timeframe is exhausted.

(i) If the requested information or clarification(s) is received from the Non-Participating Provider within the timeframe and manner it is requested, the additional information or clarification(s) will be presented at a Peer Review meeting.

(ii) If the requested information or clarification is not received within the timeframe and manner requested, the Non-Participating Provider's Credentialing Application, absent the requested information, will be reviewed at a Peer Review meeting. At such meeting, the Peer Review Committee may review the Application based on available information or find it to be incomplete.

(iii) If the Non-Participating Provider's Credentialing Application is found to be incomplete by the Peer Review Committee, the Senior Credentialing Representative, Quality, or his/her designee shall send a letter to the Non-Participating Provider by signature confirmation mail of the decision and a copy of the letter shall be placed in the File. The Application will continue to be considered incomplete until such time that the required information is received, or the credentialing timeframe is exhausted, as set forth herein.

(iv) If a Non-Participating Provider's Credentialing Application is found to be incomplete by the Peer Review Committee for failure to submit requested information or clarification(s), such action is not subject to the appeal procedures set forth in Articles XVIII, XIX or XX.

(v) If a Non-Participating Provider's Credentialing Application is found to be incomplete by the Peer Review Committee for failure to submit requested information or clarification(s), such action is not reported to the NPDB.

2. Denial. If a Non-Participating Provider Credentialing Application is denied by the Peer Review Committee, the Senior Credentialing Representative, Quality, or his/her designee shall send a signature confirmation letter of the decision to the Non-Participating Provider within 10 business days and a copy of the letter is placed in the Non-Participating Provider File.

A Non-Participating Provider who has been denied acceptance into the Network by the Peer Review Committee is entitled to the procedural rights set forth in Article XVIII, unless an automatic denial has occurred in accordance with Article V.C.2 or a Credentialing Application is found to be incomplete by the Peer Review Committee in accordance with Article V.D.1.

VI. ReCredentialing Process for Recredentialing Participating Providers and/or Adverse Information Received during Participating Providers' Participation in the Network

A. Recredentialing Frequency

The provisions of this Article VI shall govern the Recredentialing of Participating Providers and the Quality Assurance Program for Participating Providers. Participating Providers shall be recredentialed every three years and evidence of the Recredentialing Process shall be kept with the initial credentialing information in the File. If Participating Providers submit all required documentation for the recredentialing process as described in these policies and their continued participation is approved by the Peer Review Committee, those Participating Providers shall be deemed to be approved in the recredentialing process unless otherwise notified in writing by GEHA.

B. Procedures for Processing a Recredentialing Application:

1. By submitting a signed and dated Recredentialing Application, the Participating Provider acknowledges, consents, and agrees to all provisions with respect to the Recredentialing Process. In instances where a state requires utilization of an application which contains content unique to state requirements, the provider is required to complete the state-mandated application.

2. Recredentialing will require re-verification, if necessary, of all the items listed:

(a) Current statement from the Participating Provider, if necessary, regarding any revisions, to any of the following, which occurred since their last Credentialing Process or Recredentialing Process:

(i) Physical and mental health status that may impair the Participating Provider's ability to perform the essential functions of a Dental Health Professional with or without accommodation.

(ii) Lack of impairment due to chemical dependency/ substance abuse or unlawful use of drugs.

(iii) Suspension or limitation of hospital privileges; For Nebraska Providers, such privileges will be primary source verified.
(iv) Suspension as a Medicare or Medicaid Participating Provider or from other Federal or State government program.
(v) Inclusion of the Participating Provider on the OFAC's Specially Designated National List.
(vi) Inclusion of the Participating Provider in the EPLS.
(vii) Professional liability insurance denied, canceled, or not renewed.
(viii) State licensing investigation or action, including revocation, expiration, suspension, limitation, or restriction of state license.
(ix) DEA or state controlled dangerous substance certificate investigation or action, including revocation, expiration, suspension limitation or restriction; Any conviction of or plea of guilty or nolo contendere to a felony or misdemeanor under state or federal law except for North Carolina where only convictions of a felony or misdemeanor under state or federal law will be considered.

(b) Verification of receipt of the Recredentialing Application and signed and dated attestation from the Participating Provider including release of liability statement.
(c) Verification of receipt of a valid copy of proof of professional liability insurance from the Participating Provider, in a form acceptable by GEHA
(d) Primary Source Verification or Secondary Source Verification via copy, of DEA certificate or state controlled dangerous substance certificate, if applicable
(e) Primary Source Verification of the Sedation/Anesthesia licensure, if applicable and available; otherwise, a copy of license or an attestation,

(f) Primary Source Verification of the following
(i) Current state license
(ii) Board certification(s), if applicable
(iii) Eligibility to participate in Medicare, Medicaid, and government programs
(g) Secondary Source Verification from the Participating Provider of the following
(i) Professional liability insurance as required herein
(h) Verification from Application View of the following:

(i) Any felonies or misdemeanor since previous credentialing occurrence.

(i) Network's or CVO's query of the NPDB to determine if there have been any malpractice cases, licensing investigations/limitations, etc. against the Participating Provider since the last credentialing occurrence.

(j) Any reports of disciplinary actions published by Office of Inspector General (OIG), the Office of Foreign Assets Control (OFAC) or the Excluded Parties List System (EPLS). The Network will monitor these reports on an ongoing basis as part of its Quality Assurance Program.

(k) Review of the following data concerning the Participating Provider obtained from Connection Dental Department, if the file is not Clean, and if applicable and/or adverse to the Participating Provider:
  (i) Member complaints
  (ii) Results of quality of care or service reviews
  (iii) Member satisfaction surveys
  (iv) Participating Provider File

C. Procedures for Processing a Quality Assurance Program Occurrence

3. Upon the occurrence of an adverse Quality Assurance Program Occurrence under the procedures set forth in Article XIII below, the Dental Director may: submit the File to the next Peer Review Committee Meeting for review and recommendation; send a letter of concern to the Participating Provider; determine the Network needs to monitor the Participating Provider; determine the Network should schedule an on-site visit with the Participating Provider; terminate the Participating Provider; summarily suspend the Participating Provider; determine that no action is needed; or, decide the Participating Provider should be recredentialed sooner than the next regularly scheduled date and, if so, the Network may re-verify, if necessary, the items listed:

(a) Any of the following that occurred since the last Credentialing Process or Recredentialing Process:
  (i) Change in status as a Medicare or Medicaid or other Federal or State government program provider
  (ii) State licensing investigation or action
  (iii) Revoked, expired, suspended, or restricted state license
  (iv) DEA or state controlled dangerous substance certificate investigation or action

(v) Revoked, expired, suspended, or restricted DEA or state controlled dangerous substance certificate

(b) Primary Source Verification of the following
(i) Current state license
(ii) Status of as Medicare, Medicaid or government program provider and any reports of disciplinary actions published by Office of Inspector General (OIG)

(c) Primary Source Verification or Second Source Verification by copy of the following
(i) DEA or state controlled dangerous substance certificate, if applicable

(d)

(e) Query the NPDB to determine if there have been any malpractice cases, licensing investigations/limitations, etc. against the Participating Provider since the last credentialing occurrence.

(f) Review of the following data concerning the Participating Provider obtained from Connection Dental Department, if applicable, and/or adverse to the Participating Provider:
(i) Results of Quality Assurance Program Occurrences
(ii) Member satisfaction surveys
(iii) Participating Provider File.

4. The above information shall be gathered by the Credentialing Department and reviewed by the Dental Director and/or Peer Review Committee. The Credentialing Department shall ensure that the Dental Health Professional has a current and valid license, a valid DEA, a current and valid Sedation/Anesthesia, if applicable, or state controlled dangerous substance certificate, if applicable, and his or her Medicare/Medicaid or other government program status is still valid and current. In addition, the Credentialing Department shall query the NPDB and obtain all other information needed to ensure the Participating Provider's compliance with GEHA and URAC and NCQA standards.

VII. Decision on Recredentialing or Quality Assurance Program Occurrence for Continued Network Participation

A. Basic Requirements

1. The Participating Provider is responsible for meeting the Network's professional requirements and Credentialing and Recredentialing Criteria and providing dental care and services that are consistent with standards of good dental practice in the United States.

2. The Participating Provider must maintain sufficient staffing and equipment, appropriate office hours, physical accessibility, physical appearance, and adequacy of waiting- and examining-room spaces for its office location(s) so

that dental services can be performed within the standards of good dental practice in the United States.

3. The Participating Provider is responsible for notifying the Network of any changes to credentialing information and for producing information adequate to properly evaluate the ability to meet the qualifications for continued participation in the Network, including, but not limited to, his/her experience, background, training, demonstrated competence, utilization patterns or work habits, to resolve any doubts or conflicts, and to clarify information as requested.

4. The Participating Provider is responsible for providing additional information or clarification(s) regarding Recredentialing and Quality Assurance Program Occurrences if requested by the Peer Review Committee. Additional information and clarification(s) may include, but is not limited to, copies of dental records, and charging and treatment information (including x-rays and diagnostic records). Failure of a Participating Provider to submit information or clarification(s) upon request by the Peer Review Committee may result in voluntary termination by the Participating Provider.

B. Procedures for Processing Recredentialing Applications or Reviewing a Quality Assurance Program Occurrence

1. Prior to each Peer Review Committee, the Chairperson or Co-Chair will remind committee members to consider Conflict of Interest issues. If a Conflict of Interest exists for any committee member, the member shall not participate in deliberation and/or voting on any matter related to the File. If there are any questions concerning whether a Conflict of Interest exists, members should address questions to the Chairperson before any activity on the File. Whenever a conflict exists, the minutes of the relevant meeting will reflect the disclosure of the fact of a member's conflict and that the member did not participate in deliberation or voting on the matter.

2. The meetings of the Peer Review Committee and the Files will be considered confidential. The Chairperson or Co-Chair will remind the Peer Review Committee prior to each committee meeting of the necessity of confidentiality. The Files shall not be subject to discovery, subpoena, or other means of legal compulsion of their release.

C. Grounds for Denial of Recredentialing Application or Continued Network Participation

1. Criteria for Automatic Denial: A Participating Provider may be automatically denied for any of the reasons described in Article XVII.B. This action shall be final except when a bona fide dispute exists as to whether the circumstances have occurred. No Participating Provider shall be entitled to the procedural rights set forth in Articles XVIII, XIX and XX, as the result of an automatic denial imposed pursuant to this section.

2. Criteria for Voluntary Termination: A Participating Provider's Provider Agreement and participation in the Network may be voluntarily terminated for any reason set forth in Article XVII.A, including but not limited to not submitting

required Recredentialing documents, clarification(s), or information that is requested by the Peer Review Committee in the Recredentialing or Quality Assurance Program processes. No Participating Provider shall be entitled to the procedural rights set forth in Articles XVIII, XIX and XX, as the result of a voluntary termination imposed pursuant to this section.

3. Criteria for denial of a Recredentialing Application: The Peer Review Committee may deny a Recredentialing Application for any reason set forth in these Policies and Procedures and the Connection Dental Recredentialing Criteria, as amended from time to time. Unless the denial is based on automatic denial or voluntary termination as outlined above, or a non-clinical termination as outlined in Article XVII.D.2, Participating Provider shall be entitled to the procedural rights to the extent permitted under Articles XVIII, XIX and XX, as applicable.

4. Criteria for denial due to Quality Assurance Program: The Peer Review Committee may deny a Participating Provider continued Network participation based on a Quality Assurance Program Occurrence for any reason set forth in these Policies and Procedures and the Connection Dental Recredentialing Criteria, as amended from time to time. Unless the denial is based on automatic denial or voluntary termination as outlined above, or a non-clinical termination as outlined in Article XVII.D.2, Participating Provider shall be entitled to the procedural rights to the extent permitted under Articles XVIII, XIX and XX, as applicable.

D. Decision on Continued Network Participation

1. The Chairperson, Co-Chair and the Peer Review Committee will review the Recredentialing Application or Quality Assurance Program Occurrence information and make decisions at a committee meeting and determine if the Participating Provider will be granted continued participation in the Network.

(a) Approval. If the Peer Review Committee approves a Participating Provider Recredentialing Application or Quality Assurance Program Occurrence, the Credentialing Department will not send notification to the Participating Provider. Recredentialing Applications and/or Quality Assurance Program Occurrences are approved by the Peer Review Committee unless Participating Providers are otherwise notified by GEHA.

(b) Deferral. If the process is deferred by the Peer Review Committee, the Credentialing Supervisor or the Senior Credentialing Representative, Quality shall follow up in good faith to request information from a clinical peer of the Participating Provider or a Network Representative, a Network Representative, or from the Participating Provider by means of telephone, email, fax or by written request.

(i) If the requested information is received from the Participating Provider within the timeframes and

manner specified in the request, the additional information will be presented at a Peer Review meeting.

(ii) If the requested information is not provided by the Participating Provider within the time and manner specified in the request, the Peer Review Committee may review the Recredentialing Application or Quality Assurance Program Occurrence based on the available information or if found to be incomplete.

(c) Incomplete. If the Peer Review Committee finds a Participating Provider's File to be incomplete following the deferral process in Article VII.D.1.b(ii) above, a Network Representative will notify the Participating Provider in writing by signature confirmation mail, within ten 10 days of the decision, that failure of the Participating Provider to submit the requested information or clarification(s) within 30 days of receipt of the notification that the File is incomplete will result in the Participating Provider's voluntarily termination from the Network and of his or her Provider Agreement.

(i) A Participating Provider who has voluntarily terminated his or her participation in the Network and agreement with the Network by failing to submit information requested by the Peer Review Committee as a result of the review of a Recredentialing Application or Quality Assurance Program Occurrence is not entitled to the procedural rights set forth in Articles XVIII, XIX and XX.

(d) Denial. If a Participating Provider Recredentialing Application or continued participation due to a Quality Assurance Program Occurrence is denied by the Peer Review Committee, the Credentialing Supervisor or his/her designee shall send a signature confirmation letter of the decision to the Participating Provider within 10 business days and a copy of the letter is placed in the Participating Provider File.

A Participating Provider who has been denied continued participation in the Network by the Peer Review Committee is entitled to the procedural rights set forth in Articles XVIII, XIX and XX, as applicable, unless an automatic denial has occurred in accordance with VII.C.1 above, a voluntary termination has occurred in accordance with VII.C.2 above, or a non-clinical termination has occurred in accordance with Article XVII.D.2.

E. Effect of Termination or Summary Suspension

1. If a Participating Provider's status in the Network is terminated because the Participating Provider ceases to comply with Credentialing Criteria or the Participating Provider is denied upon a Recredentialing or a Quality Assurance Program Occurrence, if a Participating Provider is not recredentialed within the recredentialing timeframe, or if the Network summarily suspends a Participating Provider, the Network will cause the Participating Provider's locations to be removed from all directories.

VIII. Credentialing Confidentiality

The provisions of this Article VIII shall govern the confidentiality process for Dental Health Professional(s).

A. The provision encompasses the Credentialing Process/Recredentialing Process, Quality Assurance Program, Network Representative and Peer Review Committee responsibilities, and confidentiality procedures as they apply to both hard copy and electronic credentialing information at GEHA.

1. Confidentiality of credentialing information.
   (a) Hard copy Files; will be kept locked at all times
   (b) Electronic files; access to files limited by password(c) Copies of credentialing information; discarded in locked bin or shredded
2. Access to Files
   (a) Limited to authorized personnel only
   (b) Confidentiality training for authorized personnel
   (c) Confidentiality statements are signed by authorized personnel

IX. Review of Credentialing Information

A. This provision is to review credentialing information for completeness, accuracy, and conflicting information.

1. Quality audit process is completed on 100% of completed Files before consideration by the Peer Review Committee.
2. Credentialing information is reviewed for
   (a) Missing information
   (b) Inaccurate information
   (c) Inconsistent or conflicting information
   (d) Timeframes for Primary Source Verification or Secondary Source Verification; and
   (e) Timeframe for signature of application or attestation.

Files will be audited for quality and the information will be documented, reviewed, and tracked, and completion of the audit will be documented.

X. Credentialing Timeframe

A. This provision requires GEHA not to submit for review any Credentialing Application or Recredentialing Application that:

1. Is signed and dated more than 120 days prior to the Peer Review Committee review. If the applicant's signature on the attestation is over 120 days, the Provider must re-sign the attestation.
2. Contains Primary Source Verification or Secondary Source Verification information collected more than 120 days prior to review.
3. Contains evidence of a license that is not current and valid. All license verifications must include the expiration date of the license and the date it was verified. The license must be current and valid when presented to the Peer Review Committee.
4. Contains evidence of an expired Board certification, if used to demonstrate highest level of education.
5. Contains evidence of professional liability insurance that is not current and valid. Professional liability insurance must be current and valid when presented to the Peer Review Committee.

XI. Credentialing Communication Mechanisms for initial Credentialing and Recredentialing

A. The Network communicates with Providers about credentialing statuses. Credentialing statuses include: (i) Received; (ii) In Progress; and (iii) Complete. The Network will provide the credentialing status and copies of information it has obtained from outside sources (e.g., malpractice insurance carriers and state license boards) to Providers upon request by:

1. Letters
2. Phone calls
3. Postcards
4. Emails; and
5. Facsimiles.

The Network is not required to make available the following information to Providers:

1. References
2. Recommendations
3. Peer-review protected information
4. Information prohibited by state or federal law to be disclosed
5. The verification source used when credentials could not be obtained.

B. Prior to final review, the Network will accept additional information from Providers to correct incomplete, inaccurate, or conflicting credentialing information. Providers will be notified of the right to correct information by Network Representatives by:

1. Letters
2. Phone calls
3. Postcards
4. Emails; and/or
5. Facsimiles.

C. Incomplete, inaccurate, or conflicting information must be submitted to the Credentialing Department within the 120-day credentialing period unless a shorter timeframe is required by law. Submissions of corrections by Providers must be submitted by:

1. Letter
2. Email
3. Facsimile; or
4. Phone.

Receipt of the correction(s) will be documented by the Credentialing Representative showing date of receipt, the initials of who received and subject of the submitted information. Corrections will be applied by the Credentialing Representative, if applicable, and stored with the provider's file. Corrections or deletions to provider credentialing information are verified and/or vetted prior to changes being made.

D. Notification to the Provider of these rights will be provided via one of the following:

1. Provider Manual
2. Website; or
3. Other information distributed.

XII. Credentialing Determination Notification

A. Written notification by letter, postcard, email, or facsimile to Providers of the determination of the credentialing application shall be sent within the following timeframes:

1. Verification pending of initial credentialing files; as required by law during initial review, until receipt of missing documents via letter, phone, email, or facsimile or until required credentialing timeframes exhausted.

2. Approval of Credentialing Application; within 30 business days, unless otherwise required by law, of the determination via letter or postcard by mail, email, or facsimile.

3. Denial of initial Credentialing Application or termination of continued Network participation following review of a Recredentialing Application or Quality Assurance Program Occurrence that is not considered a Voluntary Termination by the Provider; within 10 business days of the determination by letter via signature confirmation mail.

4. Deferral for request by Peer Review Committee of clarification(s) or additional information from Providers; within 10 business days of the decision to defer the File by letter via signature confirmation mail.

5. Finding by Peer Review Committee of a File to be incomplete; within 10 business days of the decision by the Peer Review Committee by letter via signature confirmation mail.

XIII. Participating Provider Quality Assurance Program

A. The network performs the ongoing monitoring of Participating Provider credentials, the review of Participating Providers' care and services, and the review of Participating Provider administrative and non-clinical issues between recredentialing cycles to ensure the quality of Participating Providers and the safety of members. The Quality Assurance Program ensures that issues have been identified, and when appropriate, acted on in a timely manner during the interval between initial and recredentialing cycles.

1. The Network will monitor the Participating Provider's continuing compliance with Credentialing Criteria for Network participation using:
    - (a) Office of Inspector General (OIG) Reports, such as the OIG's excluded provider database; and
    - (b) Office of Foreign Assets Control's (OFAC's) Specially Designated Nationals List; and
    - (c) General Service Administration's Excluded Parties List System (EPLS); and
    - (d) State List of Excluded Individuals and Entities (LEIE); and
    - (e) State Licensing Boards.

2. The Network will review Participating Provider Files in which a Participating Provider ceases to comply with Network Credentialing Criteria through use of the following reporting entities:
    - (a) NPDB
    - (b) OIG Exclusion List
    - (c) OFAC Specially Designated Nationals List
    - (d) EPLS
    - (e) State Licensing Boards
    - (f) State LEIE
    - (g) Sedation/Anesthesia, if applicable
    - (h) DEA, if applicable

GEHA will review complaints or issues related to Participating Providers who may be engaged in behavior or practicing in a manner that appears is not of a quality consistent with generally accepted standards and practices of the dental community or issues related to non-compliance with the provider contract.

3. Upon the discovery of an adverse credentialing or ongoing monitoring event or adverse quality of care or services determination or adverse provider contract issue, GEHA may send a letter of concern to the Participating Provider; determine the Network needs to monitor the Participating Provider; determine the Network should schedule an on-site visit with the Participating Provider; terminate the Participating Provider; summarily suspend the Participating Provider; determine that no action is needed; decide to recredential the Participating Provider sooner than the next recredentialing date; or review the adverse information in accordance with Article VI.

XIV. GEHA Consumer Safety Credentialing Investigation

A. GEHA performs expedited review and investigation of any issue related to a potential health and safety issue with respect to a Participating Provider as part of its Quality Assurance Program. The review and investigation could be initiated based on:

1. Information discovered during the initial or Recredentialing Process, including missing or inconsistent information that could impact quality of care to consumers
2. Complaints about Participating Provider
3. Network status issues
4. Professional competency or conduct issues
5. Quality of care or service issues, including malpractice issues that may reveal factors related to quality of care or services

B. The review and investigation may include:

1. NPDB query
2. OIG status review
3. State license status review
4. DEA or state controlled dangerous substance certificate status review, if applicable
5. Sedation/Anesthesia license(s), if applicable
6. Previous credentialing occurrence reviews
7. Previous quality of care or service reviews; and/or
8. The Provider File.

C. Upon receipt of a potential health and safety issue, Network and/or Dental Plan management shall meet to determine whether the issue is or appears to be a potential significant risk to consumer health, safety, or welfare and, if so, the issue shall be reviewed by the Dental Director and/or Peer Review Committee. If appropriate, the Participating Provider shall be summarily suspended in accordance with Section C of Article XVII or other appropriate actions shall be taken.

XV. Delegation of Credentialing/Recredentialing

The Network may elect to delegate the Credentialing Process/Recredentialing Process to other dental care entities for subsets or for all the Participating Providers in the Network and Non-Participating Providers. The decision to delegate the process will be made after careful review of the entity's credentialing policies, procedures, and records. If the Credentialing Process/Recredentialing Process is delegated the following shall be included in the entity’s contract:

A. A written description of a Credentialing/Recredentialing Process that does not include financial incentives that emphasize cost over quality of care or services.

B. A statement that the Network will retain the right to approve new Participating Providers and sites and to terminate or suspend individual Participating Providers.

C. A plan to periodically review the effectiveness of the delegated entity's Credentialing Process/Recredentialing Process, and to perform site visits or electronic file reviews of the delegated entity to review its Credentialing Process/Recredentialing Process.

D. An oversight mechanism to ensure that the delegated entity functions are performed within the scope of URAC and NCQA accreditation standards, GEHA requirements, and applicable state laws.

E. A requirement that if the entity further delegates the credentialing to another entity, it will ensure the entity complies with the requirements herein, subject to prior written permission by GEHA and any applicable carrier.

F. A requirement that the entity obtain prior Network and applicable carrier approval for any adverse material change(s) to its credentialing program and/or credentialing policies and procedures.

G. By agreeing to enter a delegated credentialing arrangement, the dental care entity:

1. Acknowledges and attests that its credentialing policies and procedures are correct and complete and acknowledges that any significant misstatement or omission is grounds for withdrawal of credentialing delegation or for termination of the arrangement.

2. Releases from any liability all Network Representatives and/or the GEHA Board of Directors for their acts performed in good faith and without malice in connection with reviewing, evaluating, or acting on any adverse information related to a delegated entity’s Participating Provider’s credentials.

3. Releases from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to Network Representatives and/or the GEHA Board of Directors in good faith and without malice concerning a delegated entity’s Participating Provider’s ability, professional ethics, character, physical and mental health, emotional stability, and other qualifications necessary for participation in the Network as discussed herein.

4. Agrees that any lawsuit brought by a delegated entity’s Participating Provider against an individual or organization providing information to a Network Representative and/or the GEHA Board of Directors or against the Network or Network Representatives or the GEHA Board of Directors, shall be brought in a court, federal or state, in the state in which the defendant resides or is located.

5. Agrees to require the entity's Participating Providers to practice in an ethical manner and to provide continuous care to pat

6.Agrees to perform the delegated credentialing function in a non-discriminatory manner.

7.Agrees to provide to its designated Network Representative by email, mail or fax a quarterly report of its credentialing activities that include information about approved or denied providers. Such report shall include a current list of all providers.

8.Agrees to be bound by the terms of and to comply with all respects of these Policies and Procedures.

XVI. Credentialing Delegation

A. Prior to entering into a delegated credentialing agreement, GEHA evaluates the capability of the delegated entity to perform the credentialing functions according to GEHA requirements and consistent with URAC and NCQA Standards and applicable state laws. The evaluation includes the following:

1. Reviewing the delegated credentialing entities' credentialing criteria, policies, and procedures to ensure they meet or exceed those of GEHA, NCQA and URAC standards and applicable state laws. It should be noted that policies will also be reviewed to make sure credentialing system control measures are in place in accordance with internal policy A800.

2. The Dental Director and/or Peer Review Committee will review delegated entities' predelegation of credentialing assessments and approve or deny the delegation of credentialing.

B. Once a delegated entity is contracted, the Network will perform a periodic review (no less than annually) of the delegated entities that perform credentialing functions on behalf of GEHA. The Network will assess credentialing criteria, policies, and procedures to ensure they meet or exceed those of GEHA, URAC, and NCQA standards and applicable state laws, documentation of quality assurance activities for related delegated functions, and a sampling of initial and recredentialing files. Quarterly reporting is reviewed which includes a request for updated provider rosters and credentialing renewal dates. This information is reviewed for credentialing cycle compliance and may be utilized for ongoing monitoring.

1. The Network may request copies of the delegated entity's credentialing meeting minutes (blinded for PHI) showing the approvals for the files being reviewed.
2. Site visits/electronic file reviews will include review of a random sample of completed Provider Files. Electronic files must be sent in a secure format, and no personal health information (PHI) should be exchanged in the credentialing file review process.
3. Sample size of credentialing files will be 10 percent of the files or 50 files, whichever is less, but in no case less than 10 initial credentialing and 10 recredentialing files. If fewer than 10 Providers were credentialed or recredentialed since the last annual file audit, the Network will use the delegated entity's complete list of Providers to randomly select the files.
4. The Network will verify delegated entities' compliance with contractual requirements and policies and procedures.
    (a) The Dental Director and/or Peer Review Committee will review delegated entities' periodic reviews and approve or deny the continued delegation of credentialing or approve the continued delegation with a Corrective Action Plan (CAP) in place.
    (b) The Dental Director and/or Peer Review Committee may withdrawal the delegation of credentialing.
    (c) The Peer Review Committee may vote to terminate the delegated entity's contract with the Network.

C. The Network will institute actions to improve a delegated entity's audit results that has deficiencies or do not meet thresholds by placing the delegated entity on a CAP. If the entity is placed on a CAP, the Network will inform the delegated entity of the deficiencies and ask them to respond to the CAP within thirty (30) days. The delegated entity will then have sixty (60) days to make corrections to the identified deficiencies. The Network may take the following actions to verify deficiencies were corrected:
    1. Request updated credentialing policies and procedures after they are approved by the entities' credentialing committee
    2. Request a provider roster and audit an additional 5-10 files that were processed after the correction(s) were made.

D. The Network will document follow-up for delegated entities that have deficiencies or do not meet thresholds. If a delegated entity fails to comply with a CAP, the Dental Director and/or Peer Review Committee may withdraw the delegation of credentialing or the Peer Review Committee may terminate the delegated entity's contract with the Network.

E. An annual report of the Network's oversight of delegated credentialing activities will be reviewed by the Peer Review Committee. The review will include the following:

1. List of delegated entities, including number of providers affiliated with each entity; and date and results of the annual site survey/electronic and policy review.

XVII. Termination and Suspension Process

A. Voluntary Termination. A Participating Provider's participation in the Network shall be considered voluntarily terminated as described herein as of the date of the occurrence of any of the events described herein or the date GEHA discovers the event, whichever is later, and Participating Provider's Provider Agreement shall terminate. This action shall be final and, unless otherwise required by applicable statute or regulation, no Participating Provider shall be entitled to the procedural rights set forth in Articles XVIII, XIX or XX below as the result of a voluntary termination pursuant to this Article XVII.A. In addition, this action shall not be reported to the NPDB, unless otherwise required by law.

1. The Participating Provider fails/refuses to submit all required recredentialing documents within the 120-day Recredentialing Process deadline, as required by the Recredentialing Criteria and as reported to the Network by the Credentialing Department.

2. The Participating Provider fails/refuses to submit clarification(s) and/or additional information related to a Recredentialing Application or a Quality Assurance Program Occurrence that has been requested by a Network Representative on behalf of the Peer Review Committee as part of a Participating Provider's Recredentialing or Quality Assurance Program Occurrence review.

3. The Participating Provider retires.

4. The Participating Provider dies.

5. The Network is unable to locate the Participating Provider following a good faith attempt.

6. The Participating Provider terminates his or her Provider Agreement voluntarily or without cause. If a Participating Provider terminates his or her Provider Agreement voluntarily or without cause during an adverse action event of the Network, the Provider may not reapply to the Network until after a one-year waiting period from the date the Provider terminated his or her Provider Agreement in accordance with Article XXII below.

7. The Provider Agreement is terminated either by Participating Provider or by GEHA at the end of an initial or renewal term in accordance with the terms and conditions of the Provider Agreement.

8. The Provider Agreement is terminated by GEHA without cause during an initial or renewal term in accordance with the terms and conditions of the Provider Agreement.

9. The Provider Agreement is terminated either by GEHA or Participating Provider for an uncured default in accordance with the terms and conditions of the Provider Agreement.

B. Grounds for Automatic Termination.

A Participating Provider's participation in the Network shall be automatically terminated as described herein as of the date of the occurrence of the event described herein or the date GEHA discovers the event, whichever is later. This action shall be final except when a bona fide dispute exists as to whether the circumstances have occurred. No Participating Provider shall be entitled to the procedural rights set forth in Articles XVIII, XIX or XX below, as the result of an automatic termination imposed pursuant to this section.

1. Occurrences Affecting Licensure: The Participating Provider's license to practice in any state in which the Participating Provider is or will be providing services pursuant to a Provider Agreement is revoked, suspended, expired, or restricted. If the Participating Provider's license revocation or suspension is based in whole or in part upon professional competency or a quality of care issue(s), this shall be deemed a final and adverse action with respect to the provider and the provider shall not be permitted to reapply to the Network prior to the end of a one-year waiting period. If the Participating Provider's license revocation or suspension is based in whole or in part upon non-clinical issues, such as delinquent taxes, school loans, bankruptcies or other administrative reasons, the provider shall be allowed to reapply to the Network at any time.

2. Occurrences Affecting Controlled Substances Regulation: The Participating Provider's DEA or other controlled substances number in any state in which the Participating Provider is or will be providing services pursuant to a Provider Agreement is revoked, suspended, expired, or restricted. If the Participating Provider's DEA or other controlled substances number revocation is based in whole or in part upon professional competency or a quality of care issue(s), this shall be deemed a final and adverse action with respect to the provider and the provider shall not be permitted to reapply to the Network prior to the end of a one-year waiting period. If the Participating

Provider's DEA or other controlled substances number revocation is based in whole or in part upon non-clinical issues, such as delinquent taxes, school loans, bankruptcies or other administrative reasons, the provider shall be allowed to reapply to the Network at any time.

3. Conviction of a Crime: The Participating Provider has been finally adjudicated and found guilty, or entered a plea of guilty or nolo contendere in criminal prosecution under the laws of any state or of the United States for any felony or misdemeanor or any offense reasonably related to the qualifications, functions or duties of the medical or dental profession, or for any offense an essential element of which is fraud, dishonesty or an act of violence, or for any act involving moral turpitude; with the exception of North Carolina where a plea of guilty or nolo contendere will not be considered.

4. Settlement during Criminal Prosecution. The Participating Provider previously entered a settlement with a state or federal agency during a criminal prosecution under the laws of any state or of the United States, for any felony or any offense reasonably related to the qualifications, functions, or duties of the medical or dental profession, or for any offense an essential element of which is fraud, dishonesty, or an act of violence, or for any act involving moral turpitude.

5. Exclusion from State or Federal Health Care Reimbursement Programs: The Participating Provider has been excluded, debarred, suspended, or otherwise prohibited from participation in any state or federal dental care reimbursement program including Medicare, Medicaid, TRICARE, the Federal Employees Health Benefits Program, or any other state or federal health care reimbursement program, the Participating Provider is included on the OFAC's Specially Designated Nationals List, or the Participating Provider is included in the EPLS.

6. Loss of Professional Liability Insurance: The Participating Provider fails to have, carry, or maintain professional liability insurance as required by GEHA.

C. Grounds for Summary Suspension. If, in the opinion of the Dental Director or Peer Review Committee, a Participating Provider has had a health and safety issue or is otherwise engaged in behavior or is or may be practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of consumers, the Network may summarily suspend, pending investigation, a Participating Provider's participation in the Network. Such investigation shall be conducted by the Network's internal department(s) or designee. Notification will be given to the Participating Provider by signature confirmation mail. Summary suspensions shall be effective on the date of the decision and Participating Providers will be removed from directories during the Summary Suspension

period. Due to the nature of Summary Suspensions, the investigation and notification processes will be managed on an expedited basis, including promptly notifying Participating Provider of the Summary Suspension.

D. Immediate Termination

1. Grounds for Immediate Termination Related to Clinical Matters. The Dental Director or Peer Review Committee may decide to terminate a Participating Provider's participation in the Network for any reason set forth in this Article XVII or Policies and Procedures. Such reasons shall include, but not be limited to, the following:

(a) Any finding that a Participating Provider committed professional misconduct or caused a patient harm; or

(b) A Participating Provider's credentials are found to be unsatisfactory by the Peer Review Committee and membership in the GEHA/Connection Dental Network and/or privileges granted to Participating Provider are terminated, revoked, suspended, discontinued, or not renewed pursuant to GEHA/Connection Dental Network Credentialing, Recredentialing and Quality Assurance Program Policies and Procedures; or

(c) The Participating Provider has been denied continued participation in the Network due to a Quality Assurance Program Occurrence.

2. Grounds for Immediate Termination related to Non-Clinical Matters. The Dental Director or Peer Review Committee may decide to terminate a Participating Provider's participation in the Network for the following immediate termination reasons related to non-clinical matters, which are reviewed by GEHA's legal and/or compliance department personnel to make a recommendation to the Dental Director or Peer Review Committee:

(a) Any falsification of any information on the Participating Provider's Credentialing Application or Recredentialing Application or fraud committed on any documentation submitted to the Network or another health care entity; or

(b) Any finding of unlawful or unprofessional conduct, as defined by state or federal law(s) or

(c) Intentional noncompliance with HIPAA laws or regulations.

(d) Immediate Terminations related to non-clinical matters have a separate non-clinical appeal process for Participating Providers as follows:

(i) If a Participating Provider appeals an immediate termination related to a non-clinical matter, the appeal must be submitted to the Network in writing within 30 days of the Participating Provider's receipt of his/her/its termination letter from the Network. The Manager, Provider Network or other authorized representative who was not involved in the action or decision giving rise to the dispute shall meet with another member of management who was also not involved in the initial decision to review the appeal in a fair and impartial manner and, if needed, shall seek advice from legal counsel. GEHA and Participating Provider shall use best efforts to resolve the non-clinical dispute. GEHA shall render a written decision regarding the non-clinical dispute to Participating Provider within thirty (30) days of receipt of the notice of the non-clinical dispute.

(ii) Except for Participating Providers in Washington, if the Participating Provider is unsatisfied with the result of the resolution of the non-clinical dispute, the Participating Provider may submit the matter to an arbitrator selected by the American Arbitration Association unless prohibited by applicable law, in which case applicable law shall govern this section. GEHA and Participating Provider agree to be bound by the decision of the arbitrator and accept the decision as the final determination. Judgment upon decision of the arbitrator may be entered in any court of competent jurisdiction. GEHA and Participating Provider shall each bear its own cost plus one-half (1/2) the cost of arbitration.

(iii) For Washington Providers, if the Participating Provider is unsatisfied with the result of the resolution of the non-clinical dispute, the Participating Provider may submit the matter to non-binding mediation. Such mediation shall be conducted under the Washington Uniform Mediation Act (Chapter 7.07 RCW, or any successor law) unless otherwise agreed by the parties. If any party to the mediation process

described above is unsatisfied with the results of this process, it may, by written notice to the other party and to JAMS, submit the dispute to non-binding arbitration before a single arbitrator agreed to by both parties (and if not agreed to within 30 days of the notice of arbitration, then as selected by JAMS). The arbitration shall be conducted in accordance with the JAMS Comprehensive Arbitration Rules and Procedures, except as otherwise set forth by applicable law. The parties shall be responsible for their own attorney's fees and costs incurred in preparing for and attending the arbitration. GEHA and Participating Provider shall share equally the fees of the arbitrator. While the processes described in this section are not required to the exclusion of judicial remedies, Participating Provider shall exhaust these processes prior to seeking any judicial remedy. Notifications will be given to the Participating Provider by signature confirmation mail.

E. Summary suspensions and immediate terminations shall be final and binding upon the Participating Provider unless the Participating Provider files a written notice of appeal pursuant to the procedures set forth in Articles XIX or XX below.

F. When two or more Participating Provider termination events occur simultaneously, the Participating Provider will be terminated from the Network on the earliest date of any events.

G. If a Participating Provider is placed in Summary Suspension status by the Dental Director or Peer Review Committee and a termination event for that Participating Provider occurs during that Summary Suspension period, the Summary Suspension status will end on the date immediately prior to the date of the termination event and no further review or appeals will be considered for the Summary Suspension.

H. No Participating Provider may appeal an immediate termination if the basis of the immediate termination is based on the same facts or circumstances involved in a Summary Suspension for the same Participating Provider and such Participating Provider has already exhausted his or her appeals through the Dispute Resolution and/or Appeal Reconsideration Committees.

XVIII. Peer Review Committee Reconsideration for the Denial of an Initial or Recredentialing Application or a Denial based on a Quality Assurance Program Occurrence

A. Any dispute concerning the denial of a Credentialing Application, denial of a Recredentialing Application, or a denial based on a Quality Assurance Program Occurrence pursuant to these Policies and Procedures shall be resolved by the procedures set forth in this Article XVIII and, with respect to disputes concerning the denial of an initial Credentialing Application, shall be the sole and exclusive method to resolve such disputes.

1. Adverse Action

(a) The following decisions or actions shall be deemed to be an adverse action or decision under this Article XVIII and shall entitle the Provider, thereby affected, to a Peer Review Committee Reconsideration.

(i) Denial of an initial Credentialing Application based upon a Non-Participating Provider's professional competence or conduct

(ii) Denial of Recredentialing Application based on a Participating Provider's professional competence or conduct; or

(iii) Denial of a Participating Provider's continued participation in the Network based on a Quality Assurance Program Occurrence.

b. The following grounds for denial of an initial Credentialing or a Recredentialing Application, as applicable, or the continued participation of a Participating Provider based on a Quality Assurance Program Occurrence do not entitle the Provider to a Peer Review Committee Reconsideration or any review under Article XIX or XX.

(i) The Provider has failed to timely submit an application or respond to requests for clarification or additional information requested by the Peer Review Committee that is necessary for processing the Application or File, and which, for Participating Providers, is a ground for voluntary termination.

(ii) The Network determines that a ground for automatic termination has occurred.

B. Reconsideration of Peer Review Committee Denials of Initial or Recredentialing Applications or Adverse Quality Assurance Program Occurrences

1. Notice of Adverse Action.

A Provider against whom an adverse action has been taken or recommended under this Article XVIII shall be given notice of the same within 30 days. The notice shall describe the action or

decision and the reason for it. The notice shall also state that the Provider has the right to request reconsideration within the time limits specified in these Policies and Procedures and shall contain a summary of the Provider's rights in such reconsideration.

2. Request for Reconsideration.

   A Provider shall have 30 days after his/her receipt of notice pursuant to Article XVIII.B.1 above to file a written request for reconsideration. Such request shall be delivered to the Credentialing Supervisor or his/her designee and shall be reviewed at a Peer Review Committee meeting. A Provider who fails to request reconsideration within the time and in the manner specified herein waives any right to such a reconsideration and to any arbitration to which he or she might otherwise be entitled. Absent good cause, such waiver shall constitute acceptance of the adverse action or decision, and the action shall be final upon the expiration of the 30-day period.

3. Time and Place of Reconsideration.

   The reconsideration review will take place at a Peer Review Committee Meeting. Provider is notified of time, place, and date of reconsideration meeting to be held.

4. Reconsideration Committee.

   The reconsideration shall be heard by the Peer Review Committee. The Peer Review Committee shall be required to objectively consider and decide the case with good faith. The Chairperson or Co-Chair will preside over the reconsideration process and determine the order of the reconsideration procedure.

5. Conduct of Reconsideration.

   (a) During a reconsideration review meeting, the following information will be presented to the Peer Review Committee members for examination:

      (i) Initial credentialing and/or recredentialing information, including but not limited, to Credentialing Application, Recredentialing Application, and supporting documents.

      (ii) Adverse Action documents with Peer Review Committee's rationale for denial/termination.

      (iii) Provider reconsideration documentation including, but not limited to, any relevant evidence from Provider or

other applicable sources. A Provider may only submit written material to be reviewed.

(iv) Any other documents in the Provider File.

(b) The Peer Review Committee shall review all submitted documentation objectively and decide the case with good faith. In reaching a decision, the Peer Review Committee shall be entitled to consider any pertinent material contained on file with the Network, and all other information that can be considered, pursuant to these Policies and Procedures in connection with the Credentialing Application or Recredentialing Application.

(c) A record of the reconsideration shall be kept with sufficient accuracy such that an informed and valid judgment can be made by anybody that may later be called upon to review the record and render a decision. The Peer Review Committee may select the method to be used for making the record, such as electronic recording unit, detailed transcription, or minutes of the proceedings.

(d) The Chairperson or Co-Chair upon a showing of good cause may grant requests for postponement of the reconsideration review. The Peer Review Committee may recess the reconsideration proceedings and reconvene it without additional notice for the convenience of the participants or for the purpose of obtaining additional evidence or consultation. Upon conclusion of a presentation of any additional evidence, the reconsideration review shall be concluded

6. Report of Reconsideration Review

The basis of the Peer Review Committee's findings and/or reconsideration decision(s) in the matter shall be placed in the Provider's File.

7. Effect of Result.

(a) If a decision of the Peer Review Committee is favorable to the Provider, notice shall promptly be sent to the Provider involved informing him or her of action taken. Copy of notice will be kept in the Provider's File.

(b) If a decision of the Peer Review Committee is favorable to the Provider, such results shall become the final decision of the Peer Review Committee, and the matter shall be closed.

(c) If a decision of the Peer Review Committee continues to be adverse to the Provider, the Peer Review Committee shall cause notice of the decision to be given to the Provider via

signature confirmation mail. Copy of notice will be kept in the File.

(d) If a final decision of the Peer Review Committee continues to be adverse to a Non-Participating Provider with respect to a Credentialing Application, the Non-Participating Provider shall be bound by the decision. If a final decision of the Peer Review Committee continues to be adverse to a Participating Provider, the Participating Provider may file a written notice of appeal pursuant to the procedures set forth in Articles XIX or XX below.

(e) If required by Federal law, the Network will report any final adverse actions to the NPDB per Federal requirements. Voluntary terminations are not reported to the NPDB unless otherwise required by Federal law.

XIX. Appeal Process for Network Participation Disputes other than Participating Providers in Washington, New Mexico, and North Carolina

A. Any dispute concerning an adverse action, as defined below, that relates to a Participating Provider's status with the Network or that relates to a Participating Provider's professional competency or conduct that is not a denial of an initial Provider Application shall be resolved by the procedures set forth in this Article XIX and shall be the sole and exclusive method to resolve such disputes except that Washington Participating Provider disputes shall be resolved in accordance with Article XX. The Participating Provider shall be bound by any final decision rendered in accordance with said procedures.

1. Adverse Action. The following decisions or actions shall be deemed to be an adverse action or decision and shall entitle the Participating Provider, thereby affected, to the appeal process set forth in this Article XIX.

(a) Summary suspension of a Participating Provider's participation in the Network

(b) Immediate termination of a Participating Provider's participation in the Network if related to clinical matters.

(c) The Peer Review Committee’s decision on a Participating Provider's Recredentialing Application or a Quality Assurance Program Occurrence continues to be denied.

2. The following events do not entitle the Participating Provider to this appeal process related to Network participation:

(a) The occurrence of a voluntary termination under Article XVII.A.

(b) Participating Provider's automatic termination under Article XVII.B.

(c) Immediate terminations related to non-clinical matters under Article XVII.D.2.

(d) A letter of concern issued to the Participating Provider

(e) The Participating Provider is subject to monitoring by the Network; or

(f) The Participating Provider is subject to an on-site visit by a Network Representative.

3. No Participating Provider may appeal an immediate termination if the basis of the immediate termination is based on the same facts or circumstances involved in a summary suspension for the same Participating Provider and such Participating Provider has already exhausted his or her appeals through the Dispute Resolution and/or Reconsideration Committees.

B. Dispute Resolution Appeal

1. Notice of Adverse Action. A Participating Provider against whom an Adverse Action as defined in Article XIX.A.1 has been made shall be given notice of the same within 30 days. The notice shall describe the action and the reason for it. The notice shall also state that the Participating Provider has the right to request a Dispute Resolution Appeal within the time limits specified in these Policies and Procedures and shall contain a summary of the Participating Provider's rights in such an appeal.

2. Request for Dispute Resolution Appeal. A Participating Provider shall have 30 days after his/her receipt of notice pursuant to Article XIX.B.1 above to file a written request for an appeal. Such request shall be delivered to the Senior Credentialing Representative, Quality, or his or her designee, for the Network. A Participating Provider who fails to request an appeal within the time and in the manner specified herein waives any right to such an appeal and to any arbitration to which he/she might otherwise be entitled, and the action shall be final upon the expiration of the 30-day period. Such waiver shall constitute acceptance of the adverse action.

3. Informal Meeting. The Dispute Resolution Committee shall have the ability to approve appeal reconsideration in an informal meeting before a scheduled formal appeal is heard.

4. Time and Place of Dispute Resolution Appeal. The appeal review will take place at a Dispute Resolution Committee meeting. Participating Provider shall be notified of time, place and date of appeal meeting to be held. The meeting may be held telephonically, so long as all parties can hear and communicate with each other.

5. Dispute Resolution Committee. The appeal shall be heard by the Dispute Resolution Committee. The Dispute Resolution Committee shall be required to objectively consider and decide the case with good faith. A Dispute Resolution Committee Chairperson will be appointed prior to the meeting and will preside over the appeal process and determine the order of the appeal procedure. The meetings of the Committee and the files will be considered confidential. The Dispute Resolution Committee Chairperson will remind the Dispute Resolution Committee prior to each committee meeting of the necessity of confidentiality. These files shall not be subject to discovery, subpoena, or other means of legal compulsion of their release.

6. Conduct of Dispute Resolution Appeal.

(a) During the Dispute Resolution Committee meeting, the following information may be presented by the Credentialing Supervisor, Dental Director, or his or her designee to the Dispute Resolution Committee members for examination:

(i) Participating Provider's File.

(ii) Adverse Action exhibits with Dental Director, Chairperson, Co-Chair or Peer Review Committee’s rationale for termination or suspension.

(iii) Participating Provider appeal documentation including but not limited to any relevant evidence from Participating Provider or other applicable sources.

(b) The Dispute Resolution Committee shall review all submitted documentation objectively and decide the case with good faith. In reaching a decision, the Dispute Resolution Committee shall be entitled to consider any pertinent material contained on file with the Network, and all other information that can be considered in connection with the Recredentialing Application for the Recredentialing Process.

(c) A record of the appeal shall be kept with sufficient accuracy such that an informed and valid judgment can be made by any group that may later be called upon to review the record and render a decision in the matter. The Dispute Resolution Committee may select the method to be used for making the record, such as electronic recording unit, detailed transcription, or minutes of the proceedings.

(d) The Dispute Resolution Committee shall be entitled to monitor a Participating Provider for a period determined by the Dispute Resolution Committee. During the monitoring period, the Participating Provider's credentials will be reviewed based on the decision made by the committee.

(e) The Dispute Resolution Committee Chair upon a showing of good cause may grant requests for postponement of the appeal review. The Dispute Resolution Committee may recess the appeal proceedings and reconvene it without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of a presentation of oral and written evidence, the appeal review shall be concluded.

(f) For hearings involving Providers located in the State of California, the Network may be represented by an attorney only if an attorney represents the Provider. The Provider will be responsible for all costs associated with his/her representation.

7. Report of Monitoring Period. If adverse information is received during a Participating Provider's monitoring period or if at the end of a monitoring period, no adverse information was received, a teleconference shall be held with the Dispute Resolution Committee, ensuring that all parties can hear and communicate with each other, and the committee shall determine the basis for any decisions. Within 15 days after the monitoring period review is concluded, a written report of the committee's decisions and findings shall be placed in the Participating Provider's File.

8. Report of Dispute Resolution Appeal. Within 15 days after the dispute resolution appeal review is concluded, the Senior Credentialing Representative, Quality, or his or her designee, shall make a written report of the Dispute Resolution Committee's findings and decisions in the matter, and such report shall be placed in the Participating Provider's File. The report

shall include a statement of the basis for the Dispute Resolution Committee's decision(s).

9. Effect of Result.

(a) If a decision of the Dispute Resolution Committee is favorable to the Participating Provider, notice shall promptly be sent to the Participating Provider informing him or her of action taken. Copy of notice will be kept in the Participating Provider's file.

(b) If a decision of the Dispute Resolution Committee is favorable to the Participating Provider, such results shall become the final decision of the Dispute Resolution Committee, and the matter shall be closed.

(c) If the decision of the Dispute Resolution Committee continues to be adverse to the Participating Provider, the Dispute Resolution Committee shall cause notice of the decision to be given to the Participating Provider via signature confirmation mail, within 30 days. The notice shall describe the action from the Dispute Resolution Committee and the reason for it. The notice shall also state that the Participating Provider has the right to request Reconsideration Appeal within thirty (30) days and shall contain a summary of the Participating Provider's rights in such an appeal. For terminations, the notice shall include that the Participating Provider requesting a Reconsideration Appeal agrees to reimburse GEHA for one-half of GEHA’s actual costs necessary for the conduct of the hearing to the extent permitted under applicable State law, as described in Article XIX.C.1 below. A copy of the notice will be kept in the Participating Provider's File.

C. Cost of Reconsideration Appeal.

1. If a Participating Provider requests an Appeal Reconsideration for a termination and does not prevail in such appeal, the Participating Provider agrees to reimburse GEHA for one-half of GEHA’s actual costs necessary for the conduct of the hearing to the extent permitted under applicable State law. Such actual costs include the service fees, travel expenses and related costs associated with the conduct of the Appeal Reconsideration incurred by GEHA, including the fees charged by the members of the Appeal Reconsideration Committee, the Hearing Officer, any persons retained to record and transcribe the proceedings (e.g., court reporter and/or

transcriptionist) and, if necessary, any fees charged by a third party for the use of a room to conduct the hearing. The Participating Provider shall pay GEHA within thirty (30) days of receipt of the invoice for such costs. A Participating Provider who prevails in an Appeal Reconsideration shall not be required to reimburse GEHA for one-half of the costs. Provided however, any party who retains an expert witness to participate in the Appeal Reconsideration shall be responsible for payment of all fees related to the services provided by the expert witness. Appeal Reconsideration for summary suspensions do not include a formal hearing and do not require Participating Provider reimbursement.

D. Reconsideration Appeal of Summary Suspension

1. Request for Reconsideration Appeal Based Upon Summary Suspension. A Participating Provider shall have 30 days after his/her receipt of notice of a summary suspension to file a written request for an appeal. Such request shall be delivered to the Senior Credentialing Representative, Quality or his or her designee, and shall be forwarded to the Appeal Reconsideration Committee. A Participating Provider who fails to request an appeal within the time and in the manner specified herein waives any right to such an appeal and to any arbitration to which he/she might otherwise be entitled, and the action shall be final upon the expiration of the 30-day period. Such waiver shall constitute acceptance of the adverse action.

(2) Informal Meeting. The Appeal Reconsideration Committee for a Summary Suspension shall have the ability to approve appeal reconsideration in an informal meeting before scheduled formal appeal is heard.

(3) Time and Place of Reconsideration Appeal. The appeal review of a Summary Suspension will take place at an Appeal Reconsideration Committee meeting. Participating Provider shall be notified of time, place, and date of the appeal review.

(4) Appeal Reconsideration Committee. The appeal of the Summary Suspension shall be heard by the Appeal Reconsideration Committee. The Appeal Reconsideration Committee shall be required to objectively consider and decide the case with good faith. The Appeal Reconsideration Committee Chairperson will preside over the appeal process and determine the order of the appeal procedure. The meetings of the Appeal Reconsideration Committee and the files will be considered confidential. The Appeal Reconsideration Committee Chairperson will remind the Appeal Reconsideration Committee prior to each committee meeting of the necessity

of confidentiality. These files shall not be subject to discovery, subpoena, or other means of legal compulsion of their release.

5. Conduct of Reconsideration Appeal Based Upon Summary Suspension.

(a) During the Appeal Reconsideration Committee meeting, the following information may be presented by the Credentialing Supervisor, Dental Director, or his or her designee to the Appeal Reconsideration Committee members for examination:

(i) Participating Provider's File.

(ii) Adverse Action exhibits with Dental Director, Chairperson, Co-Chair or Peer Review Committee's rationale for denial/termination.

(iii) Participating Provider reconsideration and appeal documentation including but not limited to any relevant evidence from Participating Provider or other applicable sources.

(b) The Appeal Reconsideration Committee shall review all submitted documentation objectively and decide the case with good faith. In reaching a decision, the Appeal Reconsideration Committee shall be entitled to consider any pertinent material contained on file with the Network, and all other information that can be considered, pursuant to these Policies and Procedures.

(c) A record of the appeal shall be kept with sufficient accuracy such that an informed and valid judgment can be made by any group that may later be called upon to review the record and render a decision in the matter. The Appeal Reconsideration Committee may select the method to be used for making the record, such as electronic recording unit, detailed transcription, or minutes of the proceedings.

(d) The Appeal Reconsideration Committee Chairperson, upon a showing of good cause, may grant requests for postponement of the reconsideration appeal review. The Appeal Reconsideration Committee may recess the reconsideration appeal proceedings and reconvene it without

additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of a presentation of oral and written evidence, the appeal review shall be concluded.

6. Report of Monitoring During Summary Suspensions. If adverse information is received during a Participating Provider's summary suspension period or if no adverse information is received, the Participating Provider's File will be submitted to the Peer Review Committee for additional review.

7. Report of Appeal Reconsideration Appeal for Summary Suspensions. Within 15 days after the appeal reconsideration appeal review is concluded, the Senior Credentialing Representative, Quality, or his or her designee, shall make a written report of the Appeal Reconsideration Committee's findings and decisions in the matter, and such report shall be placed in the Participating Provider's File. The report shall include a statement of the basis for the Appeal Reconsideration Committee's decision(s).

8. Effect of Result for Summary Suspensions.

(a) If a decision of the Appeal Reconsideration Committee is favorable to the Participating Provider, notice shall promptly be sent to the Participating Provider informing him or her of the action taken. Copy of notice will be kept in the Participating Provider's File.

(b) If a decision of the Appeal Reconsideration Committee is favorable to the Participating Provider, such results shall become the final decision of the Appeal Reconsideration Committee, and the matter shall be closed.

(c) If the decision of the Appeal Reconsideration Committee continues to be adverse to the Participating Provider, the Appeal Reconsideration Committee shall cause notice of the decision to be given to the Participating Provider via signature confirmation mail, within 30 days. The notice shall describe the action from the Appeal Reconsideration Committee and the reason for it. The notice shall also state the network will continue to monitor the Participating Provider's credentials until such time the network has enough information regarding the summary suspension event to review the matter in full and make a decision about the Participating Provider's network participation status. A copy of the notice will be kept in the Participating Provider's File.

E. Reconsideration Appeal Requirements for Participating Provider Terminations

1. General Notice of Time and Place for Appeal. Upon receipt from a Participating Provider of a timely and proper request for an appeal, the Senior Credentialing Representative, Quality, or his or her designee, shall schedule and arrange for an appeal. At least 30 days prior to the reconsideration appeal, the Senior Credentialing Representative, Quality shall send the Participating Provider written notice of the time, place, and date of the hearing, by signature confirmation mail, which date shall be not less than 30 days after the date of the notice. The notice of the hearing provided to the Participating Provider shall include a list of witnesses (if any) expected to testify at the appeal in support of the proposed action and a summary of the Participating Provider's rights according to these Policies and Procedures.

2. Statement of Issues and Events. The Notice of appeal shall contain a concise statement of the Participating Provider's alleged acts or omissions and/or a concise statement of any other reasons or subject matter forming the basis for the adverse action which is the subject of the hearing.

3. List of Witnesses. In addition to the list of witnesses required in the notice of appeal, at least 10 days prior to the scheduled date for commencement of the appeal, each party shall provide the other with a list of names of the individuals who, as far as then reasonably known, will give testimony or evidence in support of that party at the appeal. Admissibility of testimony to be presented by a witness not so listed shall be at the discretion of the Hearing Officer, as defined below.

4. Appeal Procedure for Participating Provider Terminations.

(a) Forfeiture of Hearing. A Participating Provider who requests an appeal pursuant to this Article but fails to appear at the hearing without good cause, as determined by the Hearing Officer, shall forfeit his/her rights to such appeal to which he or she might otherwise have been entitled. If the Hearing Officer determines that the failure to appear is without good cause, the decisions shall become final upon the expiration of 30 days from the decision of the Hearing Officer. The Senior Credentialing Representative, Quality shall notify the Participating Provider of the decision of the Hearing Officer.

(b) Hearing Officer. The Hearing Officer shall be the presiding officer. He or she shall act to maintain decorum and to

assure that all participants in the appeal process are provided a reasonable opportunity to present relevant oral and documentary evidence. He or she shall be entitled to determine the order of procedure during the appeal and shall make all rulings on matters of law, procedure, and the admissibility of evidence.

(c) Representation. The Participating Provider who requested the appeal shall be entitled to be accompanied and represented at the hearing by a member of his or her professional society, and/or by an attorney. The Network may designate an attorney to represent it at the appeal to present the facts in support of its adverse action, and to examine witnesses. For hearings involving Providers located in the State of California, the Network may be represented by an attorney only if an attorney represents the Provider. The Provider is responsible for all costs associated with her or her representation.

(d) Rights of Parties. During the appeal, each party may:

(i) Call, examine and cross-examine witnesses
(ii) Introduce any relevant evidence, including exhibits
(iii) Question any witness on any matter relevant to the issues that are the subject of the hearing
(iv) Impeach any witness
(v) Offer rebuttal of any evidence
(vi) Have a record made of the hearing in accordance with Article XIX.E.4.h below; and
(vii) Submit a written statement at the close of the hearing.

If a Participating Provider who requested the appeal does not testify in his or own behalf, he or she may be called and examined as if under cross-examination.

(e) Procedure and Evidence. At the appeal, the rules of law relating to examination of witnesses or presentation of evidence need not be strictly enforced, except that oral evidence shall be taken only on oath or affirmation. The Hearing Officer may consider any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs regardless of whether such evidence would be admissible in a court of law. Prior to or during the hearing, any party may submit memoranda concerning any procedural or factual issue, and such memoranda shall be included in the hearing record.

(f) Information Pertinent to Appeal. In reaching a decision, the Appeal Reconsideration Committee shall be entitled to consider any pertinent material contained on file in the Network and information that can be considered pursuant to these Policies and Procedures. The Appeal Reconsideration Committee may at any time take official notice of any generally accepted technical or scientific principles relating to the matter at hand of any facts that may be judicially noticed by Missouri courts. The parties to the appeal shall be informed of the principles or facts to be noticed and the same shall be noted in the hearing record. Any party shall be given the opportunity, upon timely request, to request that a principle or fact be officially noticed or to refute any officially noticed principle or fact by evidence or by written or oral presentation of authority in such manner as determined by the Hearing Officer.

(g) Burden of Proof. When an appeal relates to an adverse action the Chairperson or Co-Chair shall have the initial obligation to present evidence in support thereof, but the Participating Provider thereafter is responsible for supporting his or her challenge that the adverse action lacks any substantial factual basis or that the basis or the conclusions drawn there from are arbitrary, unreasonable, or capricious.

(h) Record of Appeal. A record of the appeal shall be kept of sufficient accuracy that an informed and valid judgment can be made by any group that may later be called upon to review the record and render a decision in the matter. The Hearing Officer shall select the method to be used for making the record, such as a court report, electronic recording unit, detailed transcription, or minutes of the proceedings. Upon written request, the Participating Provider shall be entitled to obtain a copy of the record or use an alternative recording method, at his or her own expense.

(i) Postponement. Requests for postponement of an appeal may be granted by the Hearing Officer upon showing of good cause and only if the request is made as soon as is reasonably practical.

(j) Presence of Hearing Committee Members and Vote. A majority of the Appeal Reconsideration Committee shall be present at all times during the appeal and deliberations. If a committee member is absent from any part of the

proceedings, the Hearing Officer in his or her discretion may rule that such member be excluded from further participation in the proceedings or decisions of the committee.

(k) Recesses and Adjournment. The Appeal Reconsideration Committee may recess the hearing and reconvene it without additional notice if the committee deems such recess necessary for the convenience of the participants, to obtain new or additional evidence, or if consultation is required for resolution of the matter. When presentation of oral and written evidence is complete, the hearing shall be closed. The Appeal Reconsideration Committee shall deliberate outside the presence of the parties and at such time and in such location as is convenient to the committee. The Hearing Officer shall not participate in the deliberations. Upon conclusion of the Appeal Reconsideration Committee's deliberations, the appeal shall be adjourned.

5. Report of Suspended Termination Period for Participating Provider Terminations. If adverse information is received during a Participating Provider's suspended termination period, or if at the end of a suspended termination period, no adverse information was received, a teleconference shall be held with the committee ensuring that all parties can hear and communicate with each other, and the committee shall determine the basis for any decision. Within 15 days after the suspended termination review is concluded, a written report of the committee's decisions and findings shall be placed in the Participating Provider's file.

6. Report of Appeal Review for Participating Provider Terminations. Within 15 days after the appeal review is concluded, the Senior Credentialing Representative, Quality shall make a written report of the Appeal Reconsideration Committee's findings and decisions in the matter, and such report shall be placed in the Participating Provider's File. The report shall include a statement of the basis for the Appeal Reconsideration Committee's decision(s).

7. Effect of Result for Participating Provider Terminations.

(a) If a decision of the Appeal Reconsideration Committee is favorable to the Participating Provider, notice shall promptly be sent to the Participating Provider informing him or her of action taken. Copy of notice will be kept in the Participating Provider's file.

(b) If a decision of the Appeal Reconsideration Committee is favorable to the Participating Provider, such results shall become the final decision of the Appeal Reconsideration Committee, and the matter shall be closed.

(c) If the decision of the Appeal Reconsideration Committee continues to be adverse to the Participating Provider, the Appeal Reconsideration Committee shall cause notice of the decision to be sent to the Participating Provider via signature confirmation mail. Such results shall become the final decision of the Appeal Reconsideration Committee. Copy of notice to the Participating Provider shall be kept in the Participating Provider's file. Additionally, the Network shall (i) report this adverse action to the NPDB as required by Federal Law; and (ii) terminate the Participating Provider Agreement with the Participating Provider.

XX. Appeal Process for Washington Provider Network Participation Disputes

Except as otherwise provided in the Participating Provider Agreement, this section applies to all claims and disputes between Participating Provider and GEHA that involve professional conduct or competence, which result in a change in Participating Provider's participation in the Network. Any billing disputes or adverse benefit determinations shall be resolved under the Carrier's policies. While the processes described below are not required to the exclusion of judicial remedies, Participating Provider shall exhaust these processes prior to seeking any judicial remedy.

A. Network Participation First and Second Level Appeal Panels.

1. Within thirty (30) days of the action giving rise to the Network participation dispute or controversy, the Participating Provider shall submit a written complaint initiating this dispute resolution process to GEHA at the address specified below. The complaint shall describe the issue in dispute or controversy and include any supporting documentation relevant to the issues raised.

2. GEHA shall designate a "First Level Appeal Panel" consisting of three (3) individuals, including at least one (1) Participating Provider who is not otherwise involved in Network management and who is a clinical peer of the Participating Provider submitting the complaint. The First Level Appeal Panel shall review the complaint and supporting documentation and render a decision on the matter within thirty (30) days of receiving the complaint. Written notice of the First Level Appeal Panel's dispute determination shall be delivered to the Participating Provider's address on file.

3. If the Participating Provider is unsatisfied with the result of the First Level Appeal Panel dispute determination, the Participating Provider may have the complaint considered by a "Second Level Appeal Panel" by submitting written notice to GEHA within fifteen (15) days of receipt of the First Level Appeal Panel's decision. The Second Level Appeal Panel shall be composed of at least three (3) individuals, at least one (1) of which shall be a Participating Provider who is not otherwise involved in Network management and who is a clinical peer of the Participating Provider who submitted the complaint. Further, the Second Level Appeal Panel shall include individuals who were not involved in the decision of the First Level Appeal Panel. The Second Level Appeal Panel shall review the complaint and supporting documentation and render a decision on the matter within thirty (30) days of receiving the written request for a Second Level Appeal. Written notice of the Second Level Appeal Panel's dispute determination shall be delivered to the Participating Provider's address on file.

B. Alternative Dispute Resolution.

1. If the Participating Provider is unsatisfied with the result of the Second Level Appeal, Participating Provider may submit the matter to non-binding mediation. Such mediation shall be conducted under the Washington Uniform Mediation Act (Chapter 7.07 RCW, or any successor law) unless otherwise agreed by the parties.
2. If any party to the mediation process described above is unsatisfied with the results of this process, it may, by written notice to the other party and to JAMS, submit the dispute to non-binding arbitration before a single arbitrator agreed to by both parties (and if not agreed to within 30 days of the notice of arbitration, then as selected by JAMS). The arbitration shall be conducted in accordance with the JAMS Comprehensive Arbitration Rules and Procedures, except as otherwise set forth in this section. The parties shall be responsible for their own attorney's fees and costs incurred in preparing for and attending the arbitration. GEHA and Participating Provider shall share equally the fees of the arbitrator.

XXI. Appeal Process for North Carolina Provider Network Participation Disputes

A. For Participating Providers located in the State of North Carolina, the process to follow to resolve contract disputes between GEHA, on behalf of the Payor (Carrier), and Participating Providers is:
   1. Participating Provider appeal must be in writing.

a. Appeal must be submitted within six months from the date of the decision.
b. Included with the appeals letter shall be the EOB, copy of the actual claim and description of the dispute.

2. Participating Provider appeal must be sent directly to the Network and not the Payor.
3. Network shall respond in writing within 90 days of receipt of Participating Provider's appeal.
4. Network shall respond in writing to insurer (Carrier) and Participating Provider with a letter of decision.

The Network reserves the right to request additional information deemed necessary in order to settle the dispute in a timely manner. If the Participating Provider disagrees with GEHA's response to its appeal, the dispute shall be resolved by arbitration in accordance with the Participating Provider's agreement with GEHA, unless a different mechanism is required by applicable state law or regulation.

B. If the Participating Provider is unsatisfied with the result of the resolution of the administrative dispute as outlined above, the Participating Provider may submit the matter to an arbitrator selected by the American Arbitration Association unless prohibited by applicable law, in which case applicable law shall govern this process. The Network and Participating Provider agree to be bound by the decision of the arbitrator and accept the decision as the final determination. Judgment upon decision of the arbitrator may be entered in any court of competent jurisdiction. The Network and Participating Provider shall each bear its own cost plus one-half the cost of arbitration. Disputes regarding benefits or the payment of benefits for services provided to Covered Enrollees are excluded from coverage under this provision and shall be resolved in accordance with the Payors' appeals processes. Also, issues involving the termination of a Participating Provider from the Network and any appeals or disputes related thereto are covered by the GEHA/Connection Dental Network Credentialing, Recredentialing and Quality Assurance Program Policies and Procedures, which are summarized in Articles III through VI below, and are not covered by this arbitration provision.

The above network administrative appeals/disputes provisions are solely for resolution of Network Participating Provider administrative disputes. Disputes or complaints by, or on behalf of, a Covered Enrollee are subject to the grievance processes of the Payor rather than the Network.

XXII. Appeal Process for New Mexico Provider Network Participation Disputes [*Source*: N.M.AC 13.10.16.1 – 13.10.16.14

A. Participating Providers may file a network administrative appeal relative to credentialing deadlines, network adequacy, including participation determinations based upon network composition, including provider qualifications, provider contract construction or compliance, patient standards or access to care, termination, and discrimination. Other appeals such as those related to claim payment amount or timing, claim submission requirements or compliance, utilization management practices, surprise billing reimbursement amount, rate, or timing, operation of the plan, including compliance with

any law enforceable by the Superintendent or directive issued by the Superintendent shall be filed directly with the Payor.

B. A Participating Provider shall provide the Network with written notice of an administrative dispute within 90 days of the action or decision giving rise to the administrative dispute. Such appeal can be submitted electronically or manually to the Network Senior Credentialing Representative, Quality by emailing to Brandie.Roth@geha.com or mailing to the Representative at the address of 310 N.E. Mulberry, Lee's Summit, MO 64086. The Network shall send a written acknowledgment of the grievance to the provider within five days of its receipt of the grievance using the provider's preferred communication method.

C. If confirmed in a documented communication between the Network and the provider, the Network and the provider may agree to extend any deadline imposed by this appeals policy.

D. Network may request supplemental information pertinent to the resolution of a grievance from the provider. Any such request shall be made within 10 days of the network's receipt of a grievance and shall require the provider to submit the requested supplemental information within the next 10 days.

E. Network shall respond in writing with regard to the appeal using the provider's preferred method of communication within 45 days of the later of receipt of the grievance, receipt of supplemental information requested to resolve the grievance, or the due date for submission of any requested supplemental information. The response shall include:

(1) the name(s), title(s), and qualification(s) of each person who participated in the grievance decision
(2) a statement of issue(s) decided and of the ultimate decision(s)
(3) a clear and complete explanation of the rationale for the decision and a summary of the evidence relied upon to support the decision
(4) a summary of any proposed remedial action; and
(5) information on the provider's appeal rights.

F. A provider may present oral or documentary evidence to the assigned grievance panel.

G. The assigned grievance panel will be comprised of the Peer Review Committee (PRC) and the Dental Director. The review panel shall be responsible for reviewing and deciding the provider's grievance. If the grievance raises a quality-of-care concern the panel must include a New Mexico-licensed medical professional who practices in the general area of concern. A New Mexico-licensed physician shall be included on a review panel considering complex quality-of-care concerns. No person with a conflict of interest shall participate in a decision to resolve a grievance. Employment with the carrier, standing alone, does not present a conflict of interest.

A provider grievance plan shall allow a provider to submit multiple related grievances simultaneously provided the grievances are not unduly duplicative or repetitive, and for a group of providers to assert a single grievance on behalf of multiple providers.

H. A non-participating provider may submit a grievance relative to credentialing deadlines, network adequacy, including participation determinations based on network composition, network adequacy, and discrimination. The grievance must assert and explain that the network's act or practice directly impacted the non-participating provider or a patient of that provider.

I. In the event a provider files a grievance related to termination, the provider shall be afforded a fair hearing process that provides these minimum rights and protections:

(1) the right of the provider to appear in person at a hearing before the deciding panel

(2) the right of the provider to present testimonial or documentary evidence at the hearing

(3) the right of the provider to call witnesses, and cross-examine any witness

(4) the right of the provider to be represented by an attorney or by any other person of the provider's choice

(5) the right to an expedited hearing within 14 days of the termination in those instances where the network has not provided advance written notice of termination, and the termination could result in imminent and significant harm to a covered person

(6) a written decision within 20 days after the hearing, contemporaneously delivered via the provider's preferred method carrier of communication; and

(7) if a group of providers is terminated for cause, each provider in the group shall have an individual right to a hearing. However, if any one of the providers in the group submits a grievance relating to the termination, the Network shall provide each similarly situated provider in the group with a notice of hearing, and each provider who receives such notice shall be bound by the Network's determination subject to any appeal rights.

(8) If a termination is not for cause, the network shall furnish the provider written notice at least 60 days before the effective date of termination. Such notice shall:

(1) be communicated in writing via the format preferred by the provider; and
(2) contain an explanation of the termination.

J. At the request of a provider, the superintendent (NM Department of Insurance) shall conduct an external review of a provider grievance as authorized by this section.

1. Types of grievances subject to appeal**.** The superintendent shall only review a provider grievance that pertains to:

(a) an alleged violation of a law enforceable by the superintendent
(b) alleged noncompliance with an order of the superintendent; or
(c) a termination based on a provider's alleged failure to comply with a law or order enforceable by the superintendent.

2**.** In the disposition of an appeal, the superintendent may only impose a remedy, penalty, or corrective action authorized by the New Mexico Insurance Code.

3. The superintendent shall not review a provider grievance appeal unless the provider has exhausted the network's internal grievance process.

4. A provider appeal of a grievance shall be filed no later than 30 days after the provider receives a response to the grievance, or the deadline for the response, whichever is earlier.

5. The superintendent shall not review a provider grievance appeal that does not contain the following information:

(a) the provider's name, license number, address, daytime telephone number, email address, and any relevant claim number(s)

(b) the name and phone number of the carrier

(c) certification that the grievance did not pertain to Medicaid or Medicare coverage, excluding Medicare supplement

(d) a copy of the carrier's written disposition of the grievance, or certification by the provider that the carrier did not issue a written disposition within the time allowed by law

(e) the date the provider received the carrier's written disposition of the grievance, or the date by which the carrier was required to provide a written disposition if no disposition was received; and

(f) a clear and concise statement of the issue on appeal, and the remedy requested on appeal.

L. Within 45 days of receipt of a provider grievance appeal, the superintendent shall determine whether the appeal is authorized by this section and otherwise reviewable. The superintendent may request supplemental information from the provider or Network to so determine. The time between any such request and the delivery of the requested information by the superintendent shall be excluded from the 45-day deadline imposed by this section.

M. If the superintendent determines that an appeal is not authorized or reviewable, the superintendent shall issue an order dismissing the appeal and stating the reason for dismissal.

N. If the superintendent determines that an appeal is authorized and reviewable, the superintendent shall schedule either a formal or an informal hearing pursuant to the superintendent's rules, as appropriate to the issues, facts and circumstances presented in the appeal. The order setting the hearing shall authorize a designated hearing officer to take or authorize any action authorized by law to resolve the appeal.

O. The superintendent may order the parties to an appeal to participate in formal or informal settlement discussions focused on resolving the issue on appeal. If all parties to an appeal consent, the assigned hearing officer may facilitate the settlement discussions without being disqualified from issuing a recommended decision on appeal.

P. Upon an express finding of good cause, the superintendent may waive any deadline, format or process requirement imposed by this section.

Q. No person shall be subject to retaliatory action by a carrier for submitting or supporting a grievance or appeal.

R. The Network shall maintain a detailed log of provider grievances and their resolutions for a period of no less than five years. The Network shall make the log available to the superintendent upon request.

XXIII. Suspension and Termination of Participating Providers

These Policies and Procedures include processes for suspension and termination of Participating Providers; however, the Network does not reduce the participation of Participating Providers.

XXIV. Ability to Reapply

If any action under these Policies and Procedures is deemed final and is an adverse action with respect to a Provider, or if a Participating Provider voluntarily terminates his or her Participating Provider Agreement during an adverse action event, or if a Participating Provider is terminated from the Network for contract default, the Provider may not reapply to the Network until after a one-year waiting period from the date the Provider is notified of the final denial action. Provider shall not be permitted to reapply prior to the end of such one-year period.

XXV. Records Retention

GEHA/Connection Dental Network maintains all scanned credentialing files for Network providers for a minimum of ten (10) years.