NETWORK CREDENTIALING AND SANCTIONS

ValueOptions’ program for credentialing and recredentialing providers is designed to comply with national accrediting organization standards as well as local, state and Federal laws. The program described below applies to ValueOptions’ providers. The following is not intended to be an exhaustive list; ValueOptions reserves the right to amend this list of standards.

Provider Rights

As a network provider, you have the right to:

- Review information submitted to support your credentialing application,
- Correct erroneous information collected during the credentialing process,
- Be informed of the status of your credentialing or recredentialing application, and
- Be notified of these rights.

All requests for documentation must be submitted in writing. Verbal requests for the status of a credentialing or recredentialing application can be made by calling the National Network Provider Line at 1-800-397-1630, Monday through Friday, 8 a.m. to 5 p.m. EST. ValueOptions will not release information obtained through the primary source verification process when Federal or State law prohibits disclosure.

Credentialing and Recredentialing

All providers who participate in ValueOptions’ network must be credentialed/recredentialed according to ValueOptions’ requirements. For a detailed listing of credentialing requirements for practitioners and facilities, visit www.valueoptions.com provider site and select Forms. Among these requirements is primary source verification of the following information:

- Current, valid license to practice as an independent provider at the highest level certified or approved by the state for the provider's specialty or facility/program status
- License current and valid and not encumbered by restrictions, including but not limited to probation, suspension and/or supervision and monitoring requirements
- Clinical privileges in good standing at the institution designated as the primary admitting facility, with no limitations placed on the provider's ability to independently practice in his/her specialty
- Graduation from an accredited professional school and/or highest training program applicable to the academic degree, discipline or licensure
- Current Board certification, if indicated on the application
- A copy of a current DEA and CDS Certificate, as applicable
- No adverse professional liability claims which result in settlements or judgments paid by or on behalf of the provider which disclose an instance of, or pattern of, behavior which may endanger members
• No exclusion or sanctions from government programs (i.e. Medicare/Medicaid)
• Current specialized training as required for providers

ValueOptions also requires:

• Current and adequate malpractice insurance coverage
• An appropriate work history for the provider's specialty (practitioner only)
• No adverse record of failure to follow ValueOptions’ policies, procedures or Quality Management activities. No adverse record of provider actions that violate the terms of the provider agreement
• No adverse record of indictment, arrest or conviction of any felony or any crime indicating member endangerment
• No criminal charges filed relating to the provider's ability to render services to members
• No action or inaction taken by provider that, in ValueOptions’ sole discretion, results in a threat to the health or well-being of a member or is not in the member's best interest

At credentialing or recredentialing, ValueOptions may conduct a structured site visit of potential high-volume or high-volume providers' offices. This visit includes an evaluation using ValueOptions’ site and operations standards and an evaluation of the provider's clinical record-keeping practices to ensure conformity with ValueOptions’ standards.

Organizational providers (facilities and programs) must be evaluated at credentialing and recredentialing. Those who are accredited by an accrediting body accepted by ValueOptions (currently JCAHO, CARF, COA and AOA) must have their accreditation status verified. In addition, non-accredited organizational providers must undergo a structured site visit to confirm that they meet ValueOptions’ standards. Standing with state and federal authorities and programs will be verified. (Please visit www.valueoptions.com for appropriate form.) ValueOptions will not reimburse a provider if a service is a non-credentialed and/or non-contracted non-Covered Benefit. All locations where services are rendered or that fall under the same tax identification number will be considered a part of the ValueOptions network.

Recredentialing

ValueOptions requires that providers and organizational providers undergo recredentialing every three years.

Recredentialing will begin approximately six months prior to the expiration of the credentialing cycle. Providers are sent a recredentialing application that must be completed in its entirety, signed and returned to ValueOptions as soon as possible, with all requested information attached. Failure to comply with our request may result in immediate disenrollment from the provider network.
Credentialing information that is subject to change must be re-verified from primary sources during the recredentialing process. The provider must attest to any limits on his/her ability to perform essential functions of the position and attest to absence of current illegal drug use. High-volume providers (as defined by ValueOptions) that have added a new practice location or changed group affiliations since the previous credentialing decision must undergo a structured site visit review to ensure conformity with ValueOptions’ standards. This review will include an evaluation against ValueOptions site and operations standards and an evaluation of the provider's clinical record-keeping practices to ensure conformity with ValueOptions’ standards.

**Provider Updates**

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

- Address
- Phone/fax number
- Name
- Tax identification number
- Practice Panel status (open/closed)
- Provider status with group/facility

Updating this information promptly will help ValueOptions communicate information including claims payment, correspondence, directory listings and member selection.

**ValueOptions Provider Complaints, Grievances and Appeals Processes**

There are several avenues within ValueOptions for providers and members to attain resolution to their concerns depending on the type of issue raised. Opportunities exist to present concerns and to obtain a decision concerning such issues through ValueOptions Complaint, Grievance and Appeal Processes. This process provides an effective method and dependable problem resolution procedure for the informal resolution of disputes that may arise related to the:

- provider/facility agreement
- credentialing/network termination processes
- denial of service appeals (may be filed by a provider, a member, or a member-authorized representative, who may be a provider acting on behalf of a member.)
- general complaints

**Provider Contract Disputes**

In the Provider Contract, contractual problems may be resolved at either of two steps. Complaints are reviewed and fully processed until the provider is satisfied, does not file a timely complaint or appeal, or exhausts their right of appeal. A decision becomes final whenever a
provider does not exercise their right of appeal or when a decision is made in the last step and the right of appeal no longer exists. This process excludes complaints or appeals regarding reimbursement rates for multiple network participation. ValueOptions reserves the right to amend or adjust reimbursement schedules per network.

**Level One**

Initial complaints from a provider should be submitted in writing to the local service center or provider relations department within ten (10) business days of the event that gave rise to the complaint or within ten (10) business days from the time the provider should have reasonably first become aware of the event. Correspondence should include all documentation in support of the complaint and should provide, at a minimum, the following information:

- the specific term or provision in the provider agreement in dispute. It is helpful if the provider attaches a fully executed copy of the agreement
- a clear and concise description of the nature of the complaint and how the action allegedly violated the provider agreement
- the specific remedy requested for resolution

ValueOptions will review the documentation, investigate the concern and respond in writing to the provider within thirty (30) business days of receipt of the complaint.

**Level Two**

If the provider is not satisfied with the response received from ValueOptions, a Level Two complaint may be filed within ten (10) business days of receipt of a Level One response, or in the absence of a Level One response, within fifteen (15) business days of submission of the complaint to the local service center or provider relations department. The written complaint must contain, at a minimum, the same information required in the initial complaint as well as any additional information pertinent to the grievance. The Level Two complaint will be reviewed by the local Service center or Provider relations department, who will provide a final written response within thirty (30) business days of receipt of the Level Two complaint.

**Provider Appeals Related to Credentialing, Sanctions, or Terminations**

Providers have the right to appeal any adverse National Credentialing Committee (NCC) decision regarding network participation. ValueOptions has established a Provider Appeals Committee (PAC) to hear provider appeals. This committee is comprised of representatives of major clinical disciplines, network providers and clinical representatives from corporate departments within ValueOptions, none of whom compete with the appealing provider. Members of the PAC must not have participated in the original NCC decision under review.

Providers are given written notice of the NCC’s decision, the reason for the decision, and of their right to appeal the decision along with an explanation of the applicable appeals procedures.
Providers have 30 days from the date of the NCC notice to file a written request for an appeal.

The request for an appeal should include an explanation of the reasons the provider believes the NCC reached a decision to be in error and include supporting documentation. The PAC will review the explanation provided by the provider, the information previously reviewed by the NCC, and any additional information it determines to be relevant. The PAC will support, modify or overturn the decision of the NCC. Additionally, the PAC may request additional information from the provider in order to make a determination or decision. The PAC provides written notification of its decision to the provider within 14 business days after its record is complete, with an explanation of the decision, along with appeal rights and fair hearing rights.

**Fair Hearing Process**

Providers may request a second level of appeal or a Fair Hearing when the PAC denies credentialing, recredentialing, issues a sanction or disenrolls a provider from the network based on issues related to competence or professional conduct. A request for a Fair Hearing must be made within 30 calendar days of the date of the PAC’s notification. The provider will receive written notice of the place, time and date of the Fair Hearing, which date shall not be less than 90 calendar days after the date the request for appeal is received from the provider.

Additionally, the provider will receive an explanation of the hearing procedures, and a list of witnesses, if any, expected to testify on behalf of ValueOptions. The chair of the PAC will identify peer reviewers who will participate as the Fair Hearing panel, assuring representation of the discipline of the provider requesting the appeal. These peers will not have any economic interest adverse to the provider, nor will they have participated in the decisions of the PAC or NCC. One member of the Fair Hearing panel will be selected to act as the hearing officer and will preside over the Fair Hearing. Both ValueOptions and the provider will make reasonable efforts to establish a mutually agreed upon date for the hearing. Both ValueOptions and the provider have the right to legal representation at the Fair Hearing. The provider will receive a written recommendation from the panel within 15 business days after the Fair Hearing. The Fair Hearing process as set forth above is subject to applicable state and federal law.

**Provider Sanctions**

Though ValueOptions is able to resolve most provider credentialing and quality issues through consultation and education, occasionally further action is necessary to ensure quality service delivery and protection of members. The NCC may impose provider sanctions for issues related to member complaints/grievances, quality of care or violations of state and federal laws and regulations. ValueOptions will comply with all applicable local, state and federal reporting requirements regarding professional competence and conduct to ensure the highest quality of care for our members. A provider has the right to appeal any sanction through the PAC/Fair Hearing Appeals Process set forth above. The following is a list of sanctions available to the Local Credentialing Committee, the National Credentialing Committee and the Provider Appeals Committee.
## Provider Sanctions (Individual and Facility/ Program)

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<tr>
<th>Type</th>
<th>Definition</th>
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<tr>
<td>Consultation</td>
<td>A call is placed to notify the provider of the alleged action or incident. The provider will be provided with an explanation of possible sanctions if corrective actions are not taken. The call will be documented to include the date and subject for consultation. A copy of the consultation will be placed in the provider's file. Appropriate educational materials will be sent via certified mail.</td>
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<tr>
<td>Written Warning</td>
<td>A written notice is sent to the provider notifying him/her of the alleged action or incident. Possible sanctions, if corrective actions are not taken, will be explained. A copy of the letter is retained in the provider's file; educational material is sent via certified mail. Corrective action will be monitored as necessary.</td>
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<td>Second Warning/ Monitoring</td>
<td>At the discretion of the Medical Director, a second written notice may be sent to the provider and a copy of such letter shall remain in ValueOptions’ file. Additionally, the provider may be placed on monitoring when data indicates nonconformance with standards; and, if ValueOptions determines it is in the members' best interest, ValueOptions may elect to suspend new member referrals, new member authorizations and/or redirect all current members to other providers. The provider will be given written notice via facsimile and certified mail of the issues for which he/she is being suspended. A copy of the letter is placed in the provider's file.</td>
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**Facility/Program:** An action plan will be provided consisting of steps that, when taken, will remedy the deficiencies or concerns that created the need for monitoring. The provider is expected to make a best effort to comply with the monitoring action plan. If an action plan has been sent, the provider is expected
| **Suspension** | The provider may be suspended from network participation pending resolution of issues raised. Suspension requires NCC action. During suspension, ValueOptions may elect to suspend new member referrals, new patient authorizations and/or redirect all current patients to other providers. The provider will be given written notice via facsimile and certified mail of the issues for which it is being suspended. A copy of the letter is placed in the provider’s file. The suspension may last for a period of 30 calendar days during which time an investigation may take place. The NCC may extend this time period as necessary to gather additional information. Suspension is only used for serious infractions that are probable cause for termination. |
| **Individual Providers:** The suspension may last for a period of 30 calendar days during which time an investigation may take place. The NCC may extend this time period as necessary to gather additional information. Suspension is only used for serious infractions that are probable cause for termination. |
| **Termination** | The provider may be terminated from the network. Termination requires NCC action. The provider will be given written notice via facsimile and certified mail that he/she is being terminated from the network and the reason for the termination. A copy of the letter is put in the provider's file. Members in care will be notified and given assistance for referral to a new provider for continuing care, as necessary. |
ValueOptions Network Provider Terminations

Either ValueOptions or a provider may choose to terminate the provider agreement.

- If a provider chooses to resign from the network, ValueOptions must be notified in writing as specified in the termination section of the provider contract. ValueOptions will acknowledge receipt of the provider’s request and confirm the disenrollment date. A provider who has terminated a contract voluntarily with ValueOptions and wishes to rejoin the network is not eligible for participation until six months after termination.
- If ValueOptions chooses to terminate a provider, written notification or the disenrollment including the effective date, will be given as specified in the provider’s contract.

The following are the types of terminations that can be initiated by ValueOptions:

- Automatic Termination
- Non-renewal of Provider Agreement
- Termination for Cause-Quality
- Termination for Cause-Administrative

Automatic Termination

Providers will be immediately terminated upon the happening of any of the following events:

- **Insolvency or Dissolution.** The provider, group or facility of which the provider is employed becomes insolvent, or the subject of a bankruptcy, receivership, reorganization, dissolution, liquidation, or other similar proceeding.
- **Loss of License.** The provider license issued by the state is revoked, suspended, surrendered, or not renewed.
- **Conviction of Fraud**
- **Limited Ability to Practice.** Final disciplinary action by a governmental agency or licensing board that impairs the professional ability to practice.
- **Death.** The death of the provider.

Non-Renewal of Provider Agreement

ValueOptions’ Provider Agreements are effective from the date specified on the execution page of the ValueOptions provider, Clinical Group, or Regional Care Group Agreements and can be terminated within thirty (30) calendar days prior to the renewal date of the agreement. Either party must provide written notice of their intent to terminate the agreement(s).
General Complaints and Grievances

Providers also have the opportunity to voice complaints related to issues other than those discussed above (e.g. service complaints, complaints about ValueOptions’ policies and procedures). This process helps us to get important feedback from providers about our services and to identify opportunities for improvement. NOTE: Some contracts specify different standards for responding to complaints and grievances and may employ different terminology. The standards outlined below are typical of most contracts managed by ValueOptions. However, if you have questions about the policies for any particular contract, please contact the specific ValueOptions’ Customer Service Department at the number found on the member’s insurance card.

Complaints can be made through our National Provider Line by calling **(800) 397-1630**, Monday through Friday, between 8:30 AM and 5:00 PM EST or writing:

ValueOptions, Inc.
Attn: Provider Complaint Department
P.O. Box 4080
Virginia Beach, VA 23454

All complaints are acknowledged verbally or in writing. ValueOptions’ staff will investigate and attempt to reach a satisfactory resolution of your complaint within 30 calendar days of receipt of the complaint (3 calendar days for complaints involving urgent care). A one-time extension of 15 calendar days can be taken by ValueOptions when a resolution cannot be reached within the required timeframe and the extension is solely for the benefit of a member. You will be notified verbally or in writing of the proposed action to resolve (or the reason why no action can be taken).

If you are not satisfied with ValueOptions’ efforts to resolve your complaint, you may request a formal “grievance”, either verbally or in writing, within 90 calendar days from receiving notice of a complaint resolution. The procedure for filing a grievance will be communicated to you along with the notice of the complaint resolution.

When you request a grievance, a ValueOptions’ staff member or committee, none of whom were involved in the efforts to resolve the initial complaint, will review and make a decision on the grievance. Notice of the grievance decision will be issued within 30 calendar days of receipt of your grievance request. A one-time extension of 15 calendar days can be taken by ValueOptions when resolution cannot be reached within the required timeframe and the extension is solely for the benefit of a member.

Some contracts allow for additional grievance options outside of this grievance procedure. If so, the procedure for accessing any additional grievance options will be communicated to you as part of the notice of the grievance decision.